Final Report of the Acute Care Task Force

Convened Pursuant to
House Joint Resolution 77
and House Resolution 767

Submitted to the 87th General Assembly
of the State of Illinois

June, 1992

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Prepared by
Illinois Department of Public Health
Office of Health Statistics, Policy & Planning
525 West Jefferson Street
Springfield, IL 62761

ACKNOWLEDGMENTS

This report was developed by the Illinois Department of Public Health's Office of Health Statistics, Policy and Planning, Division of Health Statistics and Policy Development. Major contributors were Laura B. Landrum, Associate Director, Office of Health Statistics, Policy and Planning; Angela Oldfield, Acting Chief; Patricia Cox, Research Economist; Harold Duckler, Senior Policy Analyst; Nancy J. McCoy, Executive Secretary; and Grace Burns, Secretary.

We gratefully acknowledge the active participation of Illinois Department of Public Health staff in recommending policy to the Acute Care Task Force and in the development of this report, including Jeff W. Johnson, Chief, Division of Governmental Affairs; Frances Meehan, Chief Counsel, Division of Legal Services; William Bell, Associate Director, Office of Health Care Regulation; Rebecca Friedman Zuber, Chief, Division of Health Care Facilities and Programs; and Ray Passeri, Chief, Division of Facilities Development.

ILLINOIS DEPARTMENT OF
PUBLIC HEALTH
A Healthier Today For A Better Tomorrow

John R. Lumpkin, M.D., Director

June 8, 1992

Members of the General Assembly:

I am pleased to present the enclosed *Final Report of the Acute Care Task Force*. The Department of Public Health was required by HJR 77 and HR 767 to establish a task force to study innovative models of health care delivery and to submit a report and recommendations for legislative and administrative actions to enable the development of those new models which hold promise for the residents of Illinois.

The Acute Care Task Force met in the winter and spring of 1992. Membership was comprised of health care professionals, payors, business, advocacy groups, chairpersons of the relevant regulatory boards (Illinois Health Facilities Planning Board, Hospital Licensing Board and Ambulatory Surgical Treatment Center Licensing Board) and legislative leadership in the House Health Care Committee and the Senate Public Health, Welfare and Corrections Committee.

After serious consideration of the issues, the Task Force recommended legislation that would authorize a rational public policy approach to health systems development in Illinois. The legislation drafted and introduced by Task Force members would require the Department of Public Health to license and regulate alternative health care demonstration models in urban, suburban, and rural areas throughout the state. These models would be studied extensively for their feasibility of operation in Illinois, impact on the health care system, effect on access to care, influence on consumer and aggregate costs, and effectiveness in delivering quality care. At the end of the demonstration period, a comprehensive evaluation would be submitted to the General Assembly for its use in determining whether the model is worthy of permanent licensure. Employing this approach would allow the interests of consumers and providers of care and the information needs of policy makers to be addressed. A process for evaluating health care delivery models for future demonstrations with General Assembly approval was developed. The Acute Care Task Force recommends two models for demonstration, birth centers and postsurgical recovery centers.

I look forward to the General Assembly evaluation of these findings and determination of the worthiness of implementing these recommendations in Illinois.

Sincerely,

John R. Lumpkin, M.D.
Director of Public Health

535 West Jefferson Street • Room 500 • Springfield, Illinois 62761
100 West Randolph Street • Suite 6-600 • Chicago, Illinois 60601

FINAL REPORT OF THE ACUTE CARE TASK FORCE
Convened Pursuant to House Joint Resolution 77 and House Resolution 767

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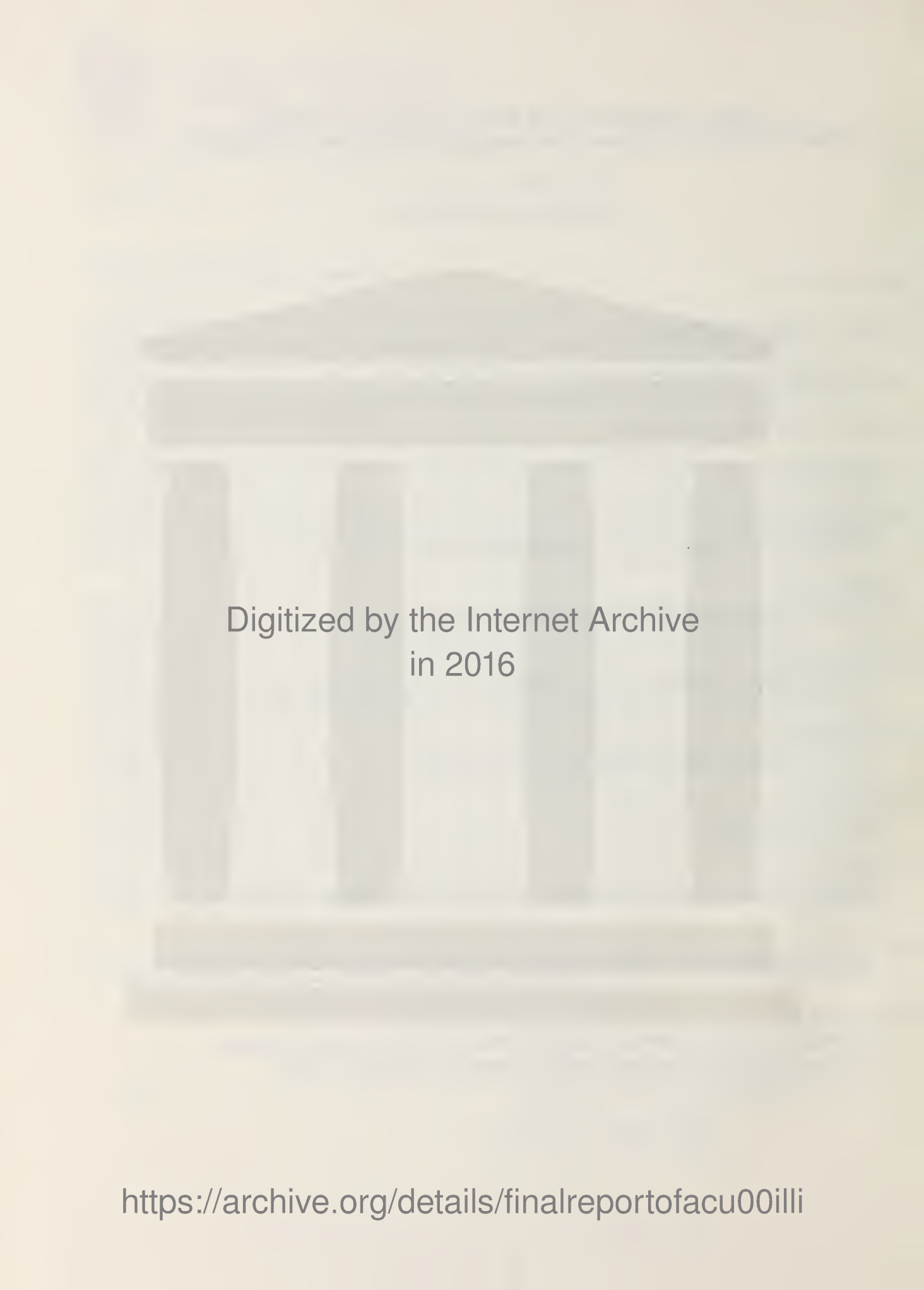

FINAL REPORT OF THE ACUTE CARE TASK FORCE
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BACKGROUND

Trends in the nation's health care delivery system have changed dramatically over the last 20 years. Current health care expenditures are recorded at more than $800 billion, and these costs continue to spiral. Growth and improvements in technology, increased access to care largely through publicly funded programs, expansion of provider services, transformation of health care delivery approaches, and diversification of corporate arrangements have all contributed to make the health care delivery system one of the largest and most complex industries in the nation.

One of the most significant recent trends in health care delivery has been the shift from inpatient to outpatient care, due in part to financial incentives. The scope of our health care statutes inadequately addresses this mode of delivery. Concern for maintaining or improving the health of vulnerable populations, coupled with dramatically increasing costs and the realization that licensure reform is in order, has sparked intense interest on the part of the legislative and executive branches in reshaping health care delivery. There is strong consensus that the time has come for change.

To address this concern, the 87th General Assembly of the State of Illinois passed House Joint Resolution 77 and House Resolution 767 (Appendix A), charging the Illinois Department of Public Health with establishing a task force to analyze various new models of acute health care delivery employed in other states and to recommend legislative and administrative actions to enable the development of those models that hold promise for Illinois residents. The Task Force was instructed to consider, at a minimum, issues related to accessibility, financing, patient health and safety, and health care systems development in its analysis and to report its findings to the Governor and General Assembly.

The Acute Care Task Force was chaired by Mardyth Pollard, J.D., the Assistant Director of the Department, and composed of representatives of the acute and ambulatory health care provider and payor communities, regulatory boards, the Department of Public Aid, and the Chairmen and Minority Spokesmen of the House Health Care and Senate Public Health, Welfare and Corrections Committees (Appendix B). It met four times over the course of three months to address its mission.

PUBLIC POLICY APPROACH

At its first meeting, John R. Lumpkin, M.D., Director of Public Health, challenged the Acute Care Task Force to reach consensus on a framework for leading Illinois to a rational public policy related to health care systems development. Recognizing the need to respond to both increased interest in alternative models for health care delivery and cautionary notes regarding their impact on quality of care and costs, Task Force members were asked to initially put aside individual differences of opinion regarding the acceptability of particular models to develop a strategy for their study.

The Director suggested that the Task Force consider a strategy whereby the Department would license and regulate alternative health care demonstration models in urban, suburban, and rural areas throughout the state. These models would be studied extensively for their feasibility of operation in Illinois, impact on the health care system, effect on access to care, influence on consumer and aggregate costs, and effectiveness in delivering quality care. At the end of the demonstration period, a comprehensive evaluation would be submitted to the General Assembly for its use in determining any models worthy of permanent licensure. Employing this approach would allow the interests of consumers, business, insurance, and providers of care to be addressed.

To implement this strategy, the Director proposed a process which defined roles for the Task Force, the General Assembly and regulatory agencies (Appendix C). Under this process, the Task Force would adopt an overall policy, recommend necessary legislation, and identify alternative health care delivery models for five-year controlled demonstrations. The General Assembly would be responsible for enacting the enabling legislation, including any models the Task Force deemed appropriate for initial study. The legislation could subsequently be amended to include additional appropriate models.

The Department, with approval from the Joint Commission on Administrative Rules, would be responsible for taking into consideration the Task Force deliberations in the promulgation of rules and for regulating the demonstration facilities. The Health Facilities Planning Board would be responsible for issuing Certificates of Need to demonstration sites in general geographic categories identified by the Task Force. The Department and the Health Facilities Planning Board would be jointly accountable for evaluating these models and generating information and recommendations to the Governor and General Assembly for their decision regarding permanent licensure of specific types of models.

The Acute Care Task Force adopted this approach in whole and requested that the Department draft general legislation to authorize pilot alternative health care delivery models. The Task Force debated the draft legislation at length, shaping and refining provisions to reflect the consensus of the group. Members almost unanimously endorsed the draft legislation (Appendix D). Introduced as House Bill 3687 (Appendix E), the bill developed a mechanism for ongoing study of alternative health care delivery models through the State Board of Health. The main thrust of the proposed legislation was to authorize the Board, through the Department, to recommend to the Governor and General Assembly the establishment of controlled five-year demonstrations designed to gain a more complete understanding of alternative models of health care delivery. No specific models were recommended in the original bill, but two models considered and approved by the Task Force were later included by amendment.

House Bill 3687 would authorize demonstrations of models deemed worthy of testing to be established in Chicago; suburban Cook County; the collar counties of DuPage, Kane, Lake, McHenry and Will; municipalities with populations greater than 50,000, other than those in previously described areas; and rural areas. The bill would establish criteria for selection of models, stipulate strong minimum evaluation requirements, and mandate the Department to define alternative models, specify the scope of the demonstration program, and adopt rules to ensure standards of care. Future models to be included in the demonstration program would be authorized only through legislative amendment upon recommendation by the Board.

DISCUSSION OF SPECIFIC MODELS

Although individual members expressed interest in a broad range of health care delivery options, the Acute Care Task Force centered its discussion of models for initial inclusion in the proposed legislation on birth centers and postsurgical recovery care centers. These two models have gained considerable attention in the General Assembly's most recent sessions, resulting in the resolution creating the Acute Care Task Force.

Last year, three bills related to these models were introduced. House Bill 488 provided for licensure and regulation of birth centers, defined as health care facilities away from the mother's usual place of residence in which births are planned to occur following a normal, uncomplicated, low-risk pregnancy. House Bill 2590 established a pilot program for determining the feasibility of authorizing medical payment for postsurgical recovery care at Ambulatory Surgical Treatment Centers (ASTCs) for periods generally not exceeding three days. Senate Bill 865 provided for a similar pilot project for ASTCs providing postsurgical and obstetric care under a 72-hour restriction on length of stay. None of these bills was enacted.

Because of the interest in these two models, the Acute Care Task Force directed the Department to prepare and present papers summarizing the experiences of other states in establishing birth centers and postsurgical recovery care centers (Appendix F). In addition, interested parties offered testimony regarding the appropriateness of these models for inclusion as pilots in House Bill 3687 (Appendix G). Finally, the Task Force considered the potential of these models to meet the selection criteria established in House Bill 3687 and developed model definitions (Appendix H). The Task Force then adopted these definitions for inclusion in the bill through amendment (Appendix D).

This report provides a brief summary of the discussion of the Task Force as it considered the proposed legislation and the inclusion of birth centers and postsurgical recovery care centers as appropriate models for Illinois demonstration programs. This description of the Task Force deliberations focuses on recorded highlights of its discussion of the key issues that shaped the provisions of House Bill 3687.

TASK FORCE DELIBERATIONS

The primary discussions of the Acute Care Task Force centered on the endorsement of a policy approach and the formulation of legislation to authorize that policy. Through its deliberations, the Task Force set about describing the framework for developing a more complete understanding of the feasibility and desirability of authorizing new models of health care delivery--models that cross the existing boundaries of licensure categories for facilities. Key factors in determining this framework were the desire to improve access to care, to reduce costs for consumers, to provide a broader range of choices of settings for needed care, to ensure quality of care regardless of setting, and to develop the data on efficacy and impact that policymakers require to make informed decisions.

Regulatory versus Statutory Issues. Throughout the discussion of this conceptual approach, the struggle to separate issues critical for inclusion in legislation from those more appropriately treated in regulation was evident. The proposed legislation could address general concerns, but specifics had to be left to the rules governing demonstrations. In addition, the desire to create a mechanism for studying the potential of models other than birth centers and recovery care centers required a broad approach in the development of selection criteria included in the proposed legislation.

The Task Force was concerned about who would select future models for pilots after their work was completed. In House Bill 3687, although the final selection would be under the authority of the General Assembly, the State Board of Health would recommend models for piloting. The role of existing regulatory boards in this process was considered carefully by the Task Force, and recommendations were made that the State Board of Health should seek advice from the licensing boards in its review of potential models.

Selection Criteria Issues. Because the responsibility for recommending future models for study would be assumed by the State Board of Health and a broad range of models might be considered, the Acute Care Task Force took particular interest in developing selection criteria for the Board's use. A key concern was the impact of alternative health care delivery models on increasing access to care. The Task Force deliberated over whether selected models should be required to demonstrate potential to increase access. Some members suggested that the two models presently under consideration would not affect access. Others argued that these new models are not currently available within the state, so their authorization and implementation in Illinois could increase access through increased choice. After lengthy consideration, this issue was resolved by specifying that one criterion for selection should be a model's potential to provide increased choices or access for patients.

Another recurring concern in the discussion of criteria was the effect a new type of health care delivery model would have on existing health facilities and programs in the same geographic area. This issue focused on recognition of the maldistribution of health professionals and consideration of the impact of alternative health care models on this problem. To resolve this issue, the Task Force incorporated a review of other states' data on the impact of new delivery models on the distribution of health professionals into the selection criteria.

Other criteria established in the legislation include the potential to meet an unmet need; to reduce health care costs; and to maintain or improve standards of health care delivery in some measurable fashion.

Demonstration Site Issues. Considerable discussion during Task Force meetings was devoted to the appropriate number and distribution of demonstration sites for individual models. Several members advocated emphasizing rural and underserved areas in determining the distribution of demonstration sites, while others suggested that covering all geographic areas was critical to fully evaluate the efficacy of alternative models. Specifically, concern was expressed that the number of demonstration sites should not be increased in underserved areas at the expense of adequately served areas because the models are alternatives not previously available anywhere. In addition to this debate, there was disagreement about the definition of underserved areas. The debate was concluded by general agreement that priority should be given to facilities located in

underserved areas; underserved areas would be identified by the Illinois Health Facilities Planning Board in the Certificate of Need approval process; and the Task Force could make recommendations to the Board regarding weights assigned to medically underserved populations within geographic areas.

Quality Assurance Issues. The question was raised regarding whether models should be licensed based upon categories of services provided instead of settings in which care is delivered. Concerns were also expressed regarding issues such as specific descriptions of transfer agreements with back-up facilities; definitions of low-risk and appropriate overnight stays; the need for additional safety factors, particularly for remote facilities without easy access to acute care; and appropriate quality monitors. Although some of these important factors were later addressed in the statutory language, it was determined that the rule-making process was the appropriate vehicle for addressing most of these issues.

Reimbursement Issues. Based upon the experience of other states, alternative health care delivery settings have experienced difficulty in qualifying for Medicaid and Medicare reimbursement without licensure. To enhance the possibility of qualifying for such reimbursement, it was determined that the demonstration sites should be licensed. In addition, it was recommended that the Department of Public Aid actively pursue Medicare and Medicaid waivers for reimbursement. It was decided that demonstration sites be required to seek all methods of compensation, including Medicare and Medicaid, although it was recognized that demonstration sites could not be expected to overcome the often inflexible regulations and guidelines of the Health Care Financing Administration for these programs.

Task Force members considered suggestions that demonstration sites be required to provide uncompensated or free care and mandated to accept Medicare and Medicaid assignment. These proposals sparked a stimulated debate with obvious disagreement about whether a test of alternative facilities should be subject to more stringent requirements than existing facilities in terms of contributions of charity care and acceptance of Medicaid and Medicare assignment. The compromise reached was an agreement that, in general, uncompensated care for persons who cannot pay or free care to low-income persons should reflect the demographics of the service area in which demonstration sites are located.

Cost Issues. A great deal of attention was given to the issue of cost effectiveness. While evidence exists that alternative models such as birth centers and recovery care centers offer cost reductions to consumers and third-party payors, Task Force members were also concerned about the impact of such models on costs to the health care delivery system as a whole. Some suggested that implementation of demonstrations would result in overbedding and increasing costs to the system. Others proposed that some models of implementation could promote greater efficiency by employing unused beds in hospital-based settings, for example. In general, due to the lack of definitive data to demonstrate the impact of alternative models on aggregate health care costs, it was determined that such investigation should become a key component of the evaluation of demonstrations.

Data Collection and Evaluation Issues. The Task Force offered guidance on other important elements of the data collection and evaluation features of the demonstration program as well. Members agreed that one of the most significant aspects of the evaluation should be the payment system. To assess models' impact on access and to identify cultural barriers, it was suggested that data collection should include demographic and economic information on persons using these models. Discussion about the appropriate length of time for the demonstration program also occurred. Several members expressed a desire to consider a time frame of three years rather than five, but concerns about offering adequate time for site selection, Certificate of Need approval, project start-up, implementation, data collection, and evaluation supported the five-year limit with a midpoint evaluation. Finally, it was determined that the impact of alternative models on hospitals and other health care settings should be assessed through the demonstration program in an effort to gain information about the overall cost effectiveness of these models and their impact on the distribution of health professionals.

Model Definition Issues. The final responsibility of the Task Force was to consider the inclusion of birth centers and postsurgical recovery care centers as initial models for demonstration under House Bill 3687. Task Force members reviewed brief summaries of available information related to each of the selection criteria established in House Bill 3687 and discussed and approved definitions for these two models (Appendix G).

Birth Centers. Timely access to high-risk care was the dominant issue during the Task Force deliberations regarding the definition of the birth center model. The major focus of the discussion was the appropriate distance between a birth center and its back-up hospital. The American College of Obstetrics and Gynecology standard for the maximum time elapse between the decision to perform a caesarean section and the actual incision is 30 minutes. Many states require back-up facilities to be within 30 minutes of the birth center or less. Several members of the Task Force advocated a more restrictive requirement. They suggested that a birth center should be located within, attached to, on the campus of, or across the street from a hospital to help assure that when changing conditions during labor and delivery required high-risk care, women would be in immediate proximity to the corresponding inpatient care.

Another suggested alternative was to allow certain birth centers to provide limited high-risk care such as caesarean and forceps delivery, and to permit these centers to be located further away from their back-up hospitals than those not providing such limited high-risk care. Concerns about possible adverse outcomes resulting from birth center staff performing such high-risk care on an infrequent basis were expressed. Alternatively, if high-risk care providers were called in, the time it would take these staff to reach the birth center was problematic. Finally, it was suggested that the absence of high-risk service capabilities in birth centers could contribute to a reduction in the number of unnecessary caesarean and forceps deliveries. Because of these arguments, this option was withdrawn from consideration. The Task Force ultimately agreed that birth centers must maintain the ability to transport a patient with complications within 15 minutes under normal travel conditions to a contracted hospital.

Another important issue in the Task Force discussion of birth centers was identification of the appropriate parties to transfer agreements. Disagreement occurred regarding whether such agreements should exist between the birth center and the back-up hospital, or whether the physician providing care at the birth center should have admitting privileges at the back-up

hospital to promote continuity of care. The Task Force determined that to facilitate the referral from the birth center to the back-up hospital, a birth center should maintain a contractual agreement including a transfer agreement with a hospital at which the physician on staff at the birth center has admitting privileges.

Finally, there was general agreement that to facilitate access to the appropriate level of high-risk care, birth centers should participate in the Illinois Perinatal System. Concerns were expressed about the possibility that this requirement would preclude transfer agreements between centers located near the state border and out-of-state back-up hospitals. However, agreements within the Illinois Perinatal System are binding on the receiving hospital and not on the sending hospital, so if the appropriate level of care is available in a hospital in a neighboring state, an Illinois birth center would not be prohibited from making a transfer to that hospital.

Recovery Care Centers. The primary issue raised in the discussion of the postsurgical recovery care center definition was a proposal to consider extending the definition to include care for patients other than those recovering from surgery. This proposal was based upon reported interest in participating in the recovery care demonstration project on the part of two hospitals providing therapy for pediatric-oncology patients who might require an overnight stay. Because postsurgical recovery care had been the focus of the presentations and testimony provided to the Task Force, and due to the mechanism set in place by House Bill 3687, it was decided that the Acute Care Task Force was not the appropriate body to consider any proposal to extend the concept to care provided to other than postsurgical patients.

CONCLUSIONS

The Acute Care Task Force was extremely successful at working cooperatively, negotiating differences, and adopting a public policy for studying models that cross licensure boundaries to reshape health care delivery and meet the changing demands on the system. House Bill 3687 captures the recommendations of the Task Force. Following the Task Force proceedings, a companion bill, Senate Bill 1814, was amended to incorporate the language of House Bill 3687. With the introduction of these bills, this recommended strategy is under the purview of the legislature to determine the value of its implementation in Illinois.

APPENDIX A.

HOUSE JOINT RESOLUTION 77 AND HOUSE RESOLUTION 767

Introduced by Representatives Mautino, Black, Phelps, Woolard, Deering and Walsh

LRB8707672CBcb

HOUSE JOINT RESOLUTION 77

WHEREAS, The acute health care delivery system has experienced considerable change and growth in technology in recent years, enabling the development of innovative models of health care delivery; and

WHEREAS, Innovative solutions should be investigated to respond to concerns about accessibility of acute health care services in both rural and urban underserved areas; and

WHEREAS, It remains the policy of the Illinois General Assembly and the State of Illinois that appropriate regulation of health care facilities to protect health and safety is in the best interests of the citizens of the State of Illinois; and

WHEREAS, The Illinois General Assembly believes that a thoughtful and coordinated approach to the development and the implementation of new models of acute health care delivery, involving providers, payors, consumers, and regulators, offers the best opportunity for the development of a safe, appropriate, and viable set of facilities for the delivery of acute health care services in Illinois; therefore be it

RESOLVED, BY THE HOUSE OF REPRESENTATIVES OF THE EIGHTY-SEVENTH GENERAL ASSEMBLY OF THE STATE OF ILLINOIS, THE SENATE CONCURRING HEREIN, that the Illinois Department of Public Health establish an Acute Care Task Force to, with the assistance of the staff of the Department, identify and analyze various new models of acute health care delivery that are being employed around the country and that, at a minimum, the Acute Care Task Force shall consider issues related to accessibility, financing, patient health and safety, and health care systems development in its analysis and development of recommendations; and be it further

RESOLVED, That the Acute Care Task Force shall be appointed and chaired by the Director of the Department of Public Health and shall consist of representatives of the acute health care provider and payor communities, consumers, regulatory personnel, and any others the Director deems able to contribute; and be it further

RESOLVED, That the membership of the Acute Care Task Force shall also include the Chairmen and Minority Spokesmen of the House Health Care and Senate Public Health, Welfare and Corrections Committees; and be it further

RESOLVED, That the Task Force shall present to the General Assembly and to the Governor, no later than March 1, 1992, a report and recommendations for legislative and administrative actions to enable the development of those new models which hold promise for the citizens of the State of Illinois; and be it further

RESOLVED, That a copy of this preamble and resolution be forwarded to the Director of the Illinois Department of Public Health.

Introduced by Representatives Lorne, Deuchler and Frederick

LRB8707327CBcb

HOUSE RESOLUTION 767

WHEREAS, Freestanding childbearing or birth centers are homelike ambulatory care facilities equipped to provide comprehensive maternity care (prenatal, labor/delivery, postpartum) to healthy women who are at low risk of complications during birth; and

WHEREAS, The first demonstration birth center was established and licensed in 1975 in New York City by the Maternity Center Association and the freestanding birth center model is now functioning at over 130 locations in 25 states; and

WHEREAS, Several long-term studies have analyzed the quality and safety of birth centers, and in addition to compliance with licensing and regulatory requirements, the quality and safety of many birth centers are further assured through the achievement of accreditation by the Commission for the Accreditation of Freestanding Birth Centers; and

WHEREAS, There remains some dissenting views within organized medicine regarding the safety and quality of birth centers; and

WHEREAS, There is some indication that charges of maternity care at a birth center in other states are approximately one-half to one-third that of hospital charges, which is especially important for the medically indigent; and

WHEREAS, The establishment of birth centers may cause affiliated hospitals' average charges to rise to reflect the increase in complexity of cases treated and may unnecessarily add the equivalent of hospital beds to a system which already has an abundance of such facilities thereby ultimately having the potential of raising rather than lowering health care costs; and

WHEREAS, Legislators are concerned about the many hospital closings in Illinois, both rural and urban, and do not wish to further jeopardize vulnerable hospitals by establishing nearby competitive birth centers (as determined by the Illinois Health Facility Planning Board as part of the Certificate of Need process); and

WHEREAS, A recent survey supported the perception that many pregnant women in Illinois would like to have the choice and opportunity to have safe, highly personalized care in a nurturing setting which encourages family participation, health education and prevention, patient autonomy, and that is also affordable; and

WHEREAS, For families in many rural areas and urban neighborhoods where long commutes for maternity services exist, continuity of care and access could definitely be enhanced by having culturally-sensitive facilities and obstetrical care providers available within their community; and

WHEREAS, A new licensing statute is necessary to establish birth centers in Illinois, along with amendments to existing hospital licensing statutes; therefore be it

RESOLVED, BY THE HOUSE OF REPRESENTATIVES OF THE EIGHTY-SEVENTH GENERAL ASSEMBLY OF THE STATE OF ILLINOIS, that the Illinois Department of Public Health (IDPH) be urged to convene a working group of representatives from at least the following organizations or constituency groups for the purpose of examining the issues of safety, quality, cost, economic impact and access pertaining to freestanding birth centers: Illinois Hospital Association, Illinois State Medical Society, Illinois Primary Health Care Association, Illinois Maternal and Child Health Coalition, Health and Medicine Policy Research Group, Illinois Academy of Pediatrics, Illinois Section of the American College of

Obstetricians and Gynecologists, Coalition for Consumer Rights, Illinois Caucus on Teenage Pregnancy, Illinois Chapter of the American College of Nurse Midwives, Illinois Public Health Association, Chicago Chapter of the National Organization of Women, Illinois Academy of Family Practitioners, Blue Cross/Blue Shield Association of Illinois, Perinatal Advisory Committee to IDPH, Illinois Perinatal Association, Illinois Rural Health Association, and the Illinois State Chamber of Commerce; and be it further

RESOLVED, That the working group shall review the studies that have analyzed the safety, quality, cost, economic impact, and access of freestanding birth centers and undertake other research and fact finding, including the possibility of site visits to existing freestanding birth centers in other states, which it deems germane to the issues; and be it further

RESOLVED, That the working group shall submit a report of its findings, conclusions, and recommendations, including any recommended legislation or demonstration projects, to the General Assembly by October 31, 1991; and be it further

RESOLVED, That a copy of this preamble and resolution be presented to the Director of the Illinois Department of Public Health.

APPENDIX B.

ACUTE CARE TASK FORCE MEMBERSHIP LIST

ACUTE CARE TASK FORCE MEMBERSHIP LIST

Mardyth Pollard, J.D., Assistant Director, Illinois Department of Public Health, Chair

Bradley L. Sexauer, Corporate Vice President for Planning, Ingalls Health System, representing Illinois hospitals

Donald R. Oder, Senior Vice President and Chief Operating Officer, Rush-Presbyterian-St. Luke's Medical Center, representing Illinois hospitals

Arvind K. Goyal, M.D., M.P.H., F.A.A.F.P., F.A.C.P.M., Family Doctor, Ltd., representing the Illinois State Medical Society

Susan M. Swider, Professor of Nursing, University of Illinois School of Nursing, representing the Illinois Nurses Association

Brenda Ballard Pflaum, Principal, William M. Mercer, Inc., representing the Illinois Manufacturers Association

Lon M. Berkeley, Executive Director, representing the Illinois Primary Health Care Association

George O'Neill, Executive Director, Shawnee Health Services, representing the Illinois Rural Health Association

Billie Paige, Shea, Rogal & Associates, LTD., representing ambulatory surgical treatment centers

Larry Barry, Illinois Life Insurance Council, representing insurance

Roberta Hardy, Chief, Bureau of Comprehensive Health Services, representing the Illinois Department of Public Aid

James P. Paulissen, M.D., M.P.H., Executive Director, DuPage County Health Department, representing local health departments

James R. Goldstone, M.D., representing the American College of Obstetrics and Gynecology

Teresa Nuno, representing the Illinois Maternal and Child Health Coalition

Jennifer Artis, Director, Southwest Community Health Center, representing the Health and Medicine Policy Research Group

Jan Gosha, C.N.M., representing the American College of Nurse-Midwives

The Honorable David D. Phelps, Chairman, House Health Care Committee

The Honorable Gerald C. Weller, Minority Spokesman, House Health Care Committee

The Honorable Margaret Smith, Chairman, Senate Public Health, Welfare and Corrections Committee

The Honorable Judy Baar Topinka, Minority Spokesman, Senate Public Health, Welfare and Corrections Committee

Pam Taylor, Chairman, representing the Illinois Health Facilities Planning Board, ex-officio

Robert F. Schinderle, Chairman, representing the Illinois Hospital Licensing Board, ex-officio

Frank A. Salvino, F.A.C.H.A., Associate Director, Cook County Hospital, and Chairman, representing the Illinois Ambulatory Surgical Treatment Center Licensing Board, ex-officio

APPENDIX C.

PROPOSED PROCESS FOR ADDRESSING H.J.R. 77 AND H.R. 767

PROPOSED PROCESS FOR ADDRESSING H.J.R. 77 AND H.R. 767

Responsible Entity	Identify Policy Approach	Identify Alternative Models	Amend or Enact Legislation	Promulgate Rules	Issue Certificate of Need(s)	Implement and Regulate Alternative Health Care Facilities	Evaluate Alternative Health Care Models
Acute Care Task Force	February/ March 1992	April/May 1992					
87th General Assembly			June 1992				
Department of Public Health/JCAR				July 1992 to July 1993		August 1993 to July 1998	Implementation Date to January 1998
Health Facilities Planning Board				July 1992 to January 1993	June 1993		

Source: Illinois Department of Public Health

APPENDIX D.

ACUTE CARE TASK FORCE ROLL CALL VOTES

ACUTE CARE TASK FORCE ROLL CALL VOTES

	ENDORSE DRAFT LEGISLATION	ACCEPT BIRTH CENTER DEFINITION	AMEND HOUSE BILL 3687 TO INCLUDE BIRTH CENTER MODEL	ACCEPT POSTSURGICAL RECOVERY CARE CENTER DEFINITION	AMEND HOUSE BILL 3687 TO INCLUDE POSTSURGICAL RECOVERY CARE CENTER MODEL
Don Oder	Yes	Yes	No	Yes	No
Bradley Sexauer	Yes	Yes	Yes	Yes	Yes
Susan Swider	Yes	Yes	Yes	Yes	Abstain
Arvind Goyal, M.D.	Yes	Yes	Yes	Yes	Yes
Brenda Pflaum	Absent	Absent	Absent	Absent	Abstain
Lon Berkeley	Yes	Yes	Yes	Yes	Yes
George O'Neill	Yea	Yes	Yes	Yes	No
Billie Paige	Yea	Yes	Yes	Yes	Yes
Larry Barry	Absent	Absent	Absent	Absent	Absent
Roberta Hardy	Absent	Absent	Absent	Absent	Absent
James Paulissen, M.D.	Yes	Yes	Yes	Yes	Yes
James Goldstone, M.D.	Yes	Yes	Yes	Yes	Yes
Teresa Nuno	Absent	Yes	Yes	Yes	Abstain
Jennifer Artis	Absent	Absent	Absent	Absent	Absent
Jan Gosha	Yes	Yes	Yes	Yes	Yes
Rep. David Phelps	No	Absent	Absent	Absent	Absent
Rep. Gerald Weller	Yes	Yes	Abstain	Yes	Abstain
Sen. Margaret Smith	Yes	Yes	Yes	Yes	Abstain
Sen. Judy Barr Topinka	Yes	Absent	Absent	Yes	Yes

APPENDIX E.

HOUSE BILL 3687

HOUSE BILL 3687

87th GENERAL ASSEMBLY
State of Illinois

1991 and 1992

Introduced April 9, 1992, by Representatives Weller – Mautino and Phelps

SYNOPSIS

(New Act; Ch. 111 1/2, par. 1153 and new par. 1155.1; Ch. 127, new par. 141.324)

Creates the Alternative Health Care Delivery Act and amends the Health Facilities Planning Act and the State Finance Act. Directs the State Board of Health to investigate and recommend new health care delivery models. Authorizes the Department of Public Health to license alternative health care models recommended by the State Board of Health and to establish demonstration programs for those models in various areas of the State. Provides for an expedited certificate of need for the models from the Health Facilities Planning Board. Provides for deposit of license fees and fines into the Regulatory Evaluation and Basic Enforcement Fund, created in the State treasury, from which moneys shall be appropriated to the Department of Public Health for implementing the Alternative Health Care Delivery Act. Effective immediately.

LRB8712370DJch

Fiscal Note Act
may be applicable

A BILL FOR

HB3687

LRB8712370DJch

AN ACT to establish and evaluate alternative health care delivery models in the State, and amending named Acts.

Be it enacted by the People of the State of Illinois, represented in the General Assembly:

Section 1. Short title. This Act may be cited as the Alternative Health Care Delivery Act.

Section 5. Purpose. The General Assembly finds that many consumers have limited access to needed health care. Other consumers have limited health care choices. Consumers of health care also experience high out-of-pocket costs for health care, and the State as a whole experiences high aggregate health care costs. The General Assembly also finds that the provision of high quality services, regardless of setting, for care is of overriding importance. Currently, there is insufficient data and information on the efficacy of alternative models of health care delivery. New and innovative solutions must be found to correct these problems. This Act is intended to foster those innovations through the development of demonstration projects to license and study alternative health care delivery systems. Furthermore, these demonstration projects shall be developed in an orderly manner and regulated by the Department of Public Health.

Section 10. Definitions. In this Act, unless the context otherwise requires:

"Alternative health care model" means a facility or program authorized under Section 35 of this Act.

"Board" means the State Board of Health.

"Department" means the Illinois Department of Public Health.

"Demonstration program" means a program to license and study alternative health care models authorized under this

Act.

"Director" means the Director of Public Health.

Section 15. License required. No health care facility or program that meets the definition and scope of an alternative health care model shall operate as such unless it is a participant in a demonstration program under this Act and licensed by the Department as an alternative health care model.

Section 20. Board responsibilities. The State Board of Health shall have the responsibilities set forth in this Section.

(a) The Board shall investigate new health care delivery models and recommend to the Governor and the General Assembly, through the Department, those models that should be authorized as alternative health care models for which demonstration programs should be initiated. In its deliberations, the Board shall use the following criteria:

(1) The feasibility of operating the model in Illinois, based on a review of the experience in other states including the impact on health professionals of other health care programs or facilities.

(2) The potential of the model to meet an unmet need.

(3) The potential of the model to reduce health care costs to consumers, costs to third party payors, and aggregate costs to the public.

(4) The potential of the model to maintain or improve the standards of health care delivery in some measurable fashion.

(5) The potential of the model to provide increased choices or access for patients.

(b) The Board shall evaluate and make recommendations to the Governor and the General Assembly, through the

Department, regarding alternative health care model demonstration programs established under this Act, at the midpoint and end of the period of operation of the demonstration programs. The report shall include, at a minimum, the following:

(1) Whether the alternative health care models improved access to health care for their service populations in the State.

(2) The quality of care provided by the alternative health care models as may be evidenced by health outcomes, surveillance reports, and administrative actions taken by the Department.

(3) The cost and cost effectiveness to the public, third-party payors, and government of the alternative health care models, including the impact of pilot programs on aggregate health care costs in the area.

(4) The impact of the alternative health care models on the health care system in that area, including changing patterns of patient demand and utilization, financial viability, and feasibility of operation of service in inpatient and alternative models in the area.

(5) The implementation by alternative health care models of any special commitments made during application review to the Illinois Health Facilities Planning Board.

(6) The continuation, expansion, or modification of the alternative health care models.

(c) The Board shall advise the Department on the definition and scope of alternative health care models demonstration programs.

(d) In carrying out its responsibilities under this Section, the Board shall seek the advice of other Department advisory boards or committees that may be impacted by the alternative health care model or the proposed model of health care delivery. The Board shall also seek input from other interested parties, which may include holding public

hearings.

(e) The Board shall otherwise advise the Department on the administration of the Act as the Board deems appropriate.

Section 25. Department responsibilities. The Department shall have the responsibilities set forth in this Section.

(a) The Department shall adopt rules for each alternative health care model authorized under this Act that shall include but not be limited to the following:

(1) Further definition of the alternative health care models.

(2) The definition and scope of the demonstration program, including the implementation date and period of operation, not to exceed 5 years.

(3) License application information required by the Department.

(4) The care of patients in the alternative health care models.

(5) Rights afforded to patients of the alternative health care models.

(6) Physical plant requirements.

(7) License application and renewal fees, which may cover the cost of administering the demonstration program.

(8) Information that may be necessary for the Board and the Department to monitor and evaluate the alternative health care model demonstration program.

(9) Administrative fines that may be assessed by the Department for violations of this Act or the rules adopted under this Act.

(b) The Department shall issue, renew, deny, suspend, or revoke licenses for alternative health care models.

(c) The Department shall perform licensure inspections of alternative health care models as deemed necessary by the Department to ensure compliance with this Act or rules.

(d) The Department shall deposit application fees, renewal fees, and fines into the Regulatory Evaluation and Basic Enforcement Fund.

(d) The Department shall assist the Board in performing the Board's responsibilities under this Act.

Section 30. Demonstration program requirements. The requirements set forth in this Section shall apply to demonstration programs.

(a) There shall be no more than 3 alternative health care models in the demonstration program for each of the following areas:

(1) The City of Chicago.

(2) Cook County outside the City of Chicago.

(3) DuPage, Kane, Lake, McHenry, and Will Counties.

(4) Municipalities with a population greater than 50,000 not located in the areas described in paragraphs (1), (2), and (3).

(5) Rural areas.

(b) Alternative health care models shall obtain a certificate of need from the Illinois Health Facilities Planning Board under the Illinois Health Facilities Planning Act before receiving a license by the Department. Alternative health care models in medically underserved areas shall receive priority in obtaining a certificate of need.

(c) An alternative health care model license shall be issued for a period of one year and shall be annually renewed if the facility or program is in substantial compliance with the Department's rules adopted under this Act. A licensed alternative health care model that continues to be in substantial compliance after the conclusion of the demonstration program shall be eligible for annual renewals unless and until a different licensure program for that type of health care model is established by legislation. The Department may issue a provisional license to any alternative

health care model that does not substantially comply with the provisions of this Act and the rules adopted under this Act if (i) the Department finds that the alternative health care model has undertaken changes and corrections which upon completion will render the alternative health care model in substantial compliance with this Act and rules and (ii) the health and safety of the patients of the alternative health care model will be protected during the period for which the provisional license is issued. The Department shall advise the licensee of the conditions under which the provisional license is issued, including the manner in which the alternative health care model fails to comply with the provisions of this Act and rules, and the time within which the changes and corrections necessary for the alternative health care model to substantially comply with this Act and rules shall be completed.

(d) Alternative health care models shall seek certification under Titles VIII and XIX of the federal Social Security Act. In addition, alternative health care models shall provide charitable care equal to or more than the percentage provided by other health care providers in the demonstration area.

(e) Alternative health care models shall, to the extent possible, link and integrate their services with nearby health care facilities.

(f) Each alternative health care model shall implement a quality assurance program with measurable benefits and at reasonable cost.

Section 35. Alternative health care models authorized. Notwithstanding any other law to the contrary, alternative health care models described in this Section may be established on a demonstration basis.

Section 40. Demonstration program funding. The

Regulatory Evaluation and Basic Enforcement Fund is created in the State treasury to collect application fees, renewal fees, and fines collected under this Act. Moneys shall be appropriated from the Fund to the Department to implement its administrative, licensure, and evaluation functions under this Act.

Section 45. License denial, suspension, or revocation. A license may be denied, suspended, or revoked, or the renewal of a license may be denied, for any of the following reasons:

(1) Violation of any provision of this Act or the rules adopted by the Department under this Act.

(2) Conviction of the owner or operator of the alternative health care model (i) of a felony or (ii) of any other crime under the laws of any state or of the United States arising out of or in connection with the operation of a health care facility. The record of conviction or a certified copy of it shall be conclusive evidence of conviction.

(3) An encumbrance on a health care license issued in Illinois or any other state to the owner or operator of the alternative health care model.

(4) Revocation of any facility license issued by the Department during the previous 5 years or surrender or expiration of the license during the pendency of action by the Department to revoke or suspend the license during the previous 5 years, if (i) the prior license was issued to the individual applicant or a controlling owner or controlling combination of owners of the applicant or (ii) any affiliate of the individual applicant or controlling owner of the applicant or affiliate of the applicant was a controlling owner of the prior license.

Section 50. Investigation of applicant or licensee; notice. The Department may on its own motion, and shall on the verified complaint in writing of any person setting forth facts which if proven would constitute grounds for the denial of an application for a license, refusal to renew a license, suspension of a license, or revocation of a license, investigate the applicant or licensee. The Department, after notice and an opportunity for a hearing, may deny an application for a licensee, revoke a license, or refuse to renew a license under Section 45 of this Act. Before denying a license application, refusing to renew a license, suspending a license, or revoking a license, the Department shall notify the applicant or licensee in writing. The notice shall specify the charges or reasons for the Department's contemplated action. If the applicant or licensee desires a hearing on the Department's contemplated action, he or she must request a hearing within 10 days after receiving the notice. A failure to request a hearing within 10 days shall constitute a waiver of the applicant's or licensee's right to a hearing.

Section 55. Hearings. The hearing requested under Section 50 shall be conducted by the Director or an individual designated in writing by the Director as a hearing officer. The Director or hearing officer may compel, by subpoena or subpoena duces tecum, the attendance and testimony of witnesses and the production of books and papers. The Director or hearing officer may administer oaths to witnesses. The hearing shall be conducted at a place designated by the Department. The procedures governing hearings and the issuance of final orders under this Act shall be according to rules adopted by the Department. All subpoenas issued by the Director or hearing officer may be served as in civil actions. The fees of witnesses for attendance and travel shall be the same as the fees for

witnesses before the circuit court and shall be paid by the party to the proceedings at whose request the subpoena is issued. If a subpoena is issued at the request of the Department, the witness fee shall be paid by the Department as an administrative expense. If a witness refuses to attend or testify, or to produce books or papers, concerning any matter on which he or she might be lawfully examined, the circuit court of the county in which the hearing is held, on application of any party to the proceeding, may compel obedience by a proceeding for contempt as in cases of a refusal to obey a similar order of the court.

Section 60. Final orders. The Director or hearing officer shall make findings of fact and conclusions of law in the matters that are the subject of the hearing, and the Director shall render a decision, or the hearing officer a proposal for decision, within 45 days after the termination of the hearing unless additional time is required by the Director or hearing officer for a proper disposition of the matter. A copy of the final decision of the Director shall be served on the applicant or licensee in person or by certified mail.

Section 65. Judicial review; deposit for costs.

(a) All final administrative decisions of the Department under this Act shall be subject to judicial review under the provisions of the Administrative Review Law and the rules adopted under that Law. "Administrative decision" is defined as in Section 3-101 of the Code of Civil Procedure. Proceedings for judicial review shall be commenced in the circuit court of the county in which the party applying for review resides. If that party is not a resident of this State, however, the venue shall be in Sangamon County.

(b) The Department shall not be required to certify any record or file any answer or otherwise appear in any

proceeding for judicial review unless the party filing the complaint deposits with the clerk of the circuit court the sum of $0.95 per page for the costs of certification. Failure by the plaintiff to make the deposit shall be grounds for dismissing the action.

Section 70. Administrative rules. The Illinois Administrative Procedure Act is expressly adopted and shall apply to all rules of the Department adopted under this Act.

Section 75. Violations; criminal penalties. Any person opening, conducting, or maintaining an alternative health care model without a license issued under this Act shall be guilty of a business offense punishable upon conviction by a fine of $10,000. Each day the violation continues shall constitute a separate offense.

Section 80. Injunction. The operation or maintenance of an alternative health care model in violation of this Act or the rules adopted under this Act is declared to be inimical to the public welfare. The Director, in addition to other remedies provided in this Act, may bring an action in the name of the People of the State, through the Attorney General, for an injunction to restrain a violation of this Act or the rules or to enjoin the future operation or maintenance of the alternative health care model.

Section 97. The Illinois Health Facilities Planning Act is amended by changing Section 3 and adding Section 5.1 as follows:

(Ch. 111 1/2, par. 1153)

Sec. 3. As used in this Act:

"Health care facilities" means and includes the following facilities and organizations:

1. An ambulatory surgical treatment center required to be licensed pursuant to the Ambulatory Surgical Treatment Center Act;

2. An institution, place, building, or agency required to be licensed pursuant to the Hospital Licensing Act;

3. Any institution required to be licensed pursuant to the Nursing Home Care Act;

4. Hospitals, nursing homes, ambulatory surgical treatment centers or kidney disease treatment centers, or health maintenance organizations maintained by the State or any department or agency thereof;

5. Kidney disease treatment centers, including a free-standing hemodialysis unit; and

6. Any health maintenance organization required to be operated pursuant to the Health Maintenance Organization Act and which:

(A) is a qualified health maintenance organization under Section 1310(d) of the Public Health Services Act; or

(B) (i) provides or otherwise makes available to enrolled participants health care services, including at least the following basic health care services: usual physician services, hospitalization, laboratory, x-ray, emergency and preventive services, and out of area coverage; (ii) is compensated (except for co-payments) for the provision of the basic health care services listed in clause (i) to enrolled participants by a payment which is paid on a periodic basis without regard to the date the health care services are provided and which is fixed without regard to the frequency, extent, or kind of health service actually provided; and (iii) provides physicians' services primarily (I) directly through physicians who are either

employees or partners of such organization, or (II) through arrangements with individual physicians or one or more groups of physicians (organized on a group practice or individual practice basis).

No federally owned facility shall be subject to the provisions of this Act, nor facilities used solely for healing by prayer or spiritual means.

No facility licensed under the Supportive Residences Licensing Act shall be subject to the provisions of this Act.

With the exception of those health care facilities specifically included in this Section, nothing in this Act shall be intended to include facilities operated as a part of the practice of a physician or other licensed health care professional, whether practicing in his individual capacity or within the legal structure of any partnership, medical or professional corporation, or unincorporated medical or professional group. Further, this Act shall not apply to physicians or other licensed health care professional's practices where such practices are carried out in a portion of a health care facility under contract with such health care facility by a physician or by other licensed health care professionals, whether practicing in his individual capacity or within the legal structure of any partnership, medical or professional corporation, or unincorporated medical or professional groups. This Act shall apply to construction or modification and to establishment by such health care facility of such contracted portion which is subject to facility licensing requirements, irrespective of the party responsible for such action or attendant financial obligation.

"Person" means any one or more natural persons, legal entities, governmental bodies other than federal, or any combination thereof.

"Consumer" means any person other than a person (a) whose major occupation currently involves or whose official

capacity within the last 12 months has involved the providing, administering or financing of any type of health care facility, (b) who is engaged in health research or the teaching of health, (c) who has a material financial interest in any activity which involves the providing, administering or financing of any type of health care facility, or (d) who is or ever has been a member of the immediate family of the person defined by (a), (b), or (c).

"State Board" means the Health Facilities Planning Board.

"Construction or modification" means the establishment, erection, building, alteration, reconstruction, modernization, improvement, extension, discontinuation, change of ownership, of or by a health care facility, or the purchase or acquisition by or through a health care facility of equipment or service for diagnostic or therapeutic purposes or for facility administration or operation, or any capital expenditure made by or on behalf of a health care facility which exceeds the capital expenditure minimum.

"Establish" means the construction of a health care facility or the replacement of an existing facility on another site.

"Major medical equipment" means medical equipment which is used for the provision of medical and other health services and which costs in excess of the capital expenditure minimum, except that such term does not include medical equipment acquired by or on behalf of a clinical laboratory to provide clinical laboratory services if the clinical laboratory is independent of a physician's office and a hospital and it has been determined under Title XVIII of the Social Security Act to meet the requirements of paragraphs (10) and (11) of Section 1861(s) of such Act. In determining whether medical equipment has a value in excess of the capital expenditure minimum, the value of studies, surveys, designs, plans, working drawings, specifications, and other activities essential to the acquisition of such equipment

shall be included.

"Capital Expenditure" means an expenditure: (A) made by or on behalf of a health care facility (as such a facility is defined in this Act); and (B) which under generally accepted accounting principles is not properly chargeable as an expense of operation and maintenance, or is made to obtain by lease or comparable arrangement any facility or part thereof or any equipment for a facility or part; and which exceeds the capital expenditure minimum.

For the purpose of this paragraph, the cost of any studies, surveys, designs, plans, working drawings, specifications, and other activities essential to the acquisition, improvement, expansion, or replacement of any plant or equipment with respect to which an expenditure is made shall be included in determining if such expenditure exceeds the capital expenditures minimum. Donations of equipment or facilities to a health care facility which if acquired directly by such facility would be subject to review under this Act shall be considered capital expenditures, and a transfer of equipment or facilities for less than fair market value shall be considered a capital expenditure for purposes of this Act if a transfer of the equipment or facilities at fair market value would be subject to review.

"Capital expenditure minimum" means $1,000,000 for major medical equipment and $2,000,000 for all other capital expenditures, both of which shall be annually adjusted to reflect the increase in construction costs due to inflation.

"Areawide" means a major area of the State delineated on a geographic, demographic, and functional basis for health planning and for health service and having within it one or more local areas for health planning and health service. The term "region", as contrasted with the term "subregion", and the word "area" may be used synonymously with the term "areawide".

"Local" means a subarea of a delineated major area that

on a geographic, demographic, and functional basis may be considered to be part of such major area. The term "subregion" may be used synonymously with the term "local".

"Areawide health planning organization" or "Comprehensive health planning organization" means the health systems agency designated by the Secretary, Department of Health, Education, and Welfare, pursuant to federal Public Law 93-641, or any successor agency.

"Local health planning organization" means those local health planning organizations that are designated as such by the areawide health planning organization of the appropriate area.

"Physician" means a person licensed to practice in accordance with the Medical Practice Act of 1987, as amended.

"Licensed health care professional" means a person licensed to practice a health profession under pertinent licensing statutes of the State of Illinois.

"Director" means the Director of the Illinois Department of Public Health.

"Agency" means the Illinois Department of Public Health.

"Comprehensive health planning" means health planning concerned with the total population and all health and associated problems that affect the well-being of people and that encompasses health services, health manpower, and health facilities; and the coordination among these and with those social, economic, and environmental factors that affect health.

"Alternative health care model" means a facility or program authorized under the Alternative Health Care Delivery Act.

(Source: P.A. 86-820; 86-1475; 87-840.)

(Ch. 111 1/2, new par. 1155.1)

Sec. 5.1. No person shall construct, modify, or establish a health care facility alternative health care

model without first obtaining a permit from the State Board.

Section 98. The State Finance Act is amended by adding Section 5.324 as follows:

(Ch. 127, new par. 141.324)

Sec. 5.324. The Regulatory Evaluation and Basic Enforcement Fund.

Section 99. This Act shall take effect upon becoming law.

ADOPTED

Introduced by Representative Hoffman

LRB8712370DJcham01

AMENDMENT TO HOUSE BILL 3687

AMENDMENT NO. 1. Amend House Bill 3687 on page 1, in lines 25 and 31, by inserting "delivery" after "care" each time it appears; and

on page 2, in lines 5, 7, and 15, by inserting "delivery" after "care" each time it appears; and

on page 3, in lines 1, 6, 10, 22, 26, 28, and 33, by inserting "delivery" after "care" each time it appears; and

on page 4, in lines 7, 10, 17, 19, 26, 31, and 33, by inserting "delivery" after "care" each time it appears; and

in line 16, by inserting "quality of" after "The"; and

after line 23, by inserting the following:

"(8) Staffing models appropriate to the demonstration program."; and

in line 24, by changing "(8)" to "(9)"; and

in line 27, by changing "(9)" to "(10)"; and

after line 29, by inserting the following:

"(11) Individuals practicing in the facility or program should be licensed or certified in their appropriate fields."; and

on page 5, in line 4, by changing "(d)" to "(e)"; and

in lines 10, 19, 23, 25, and 29, by inserting "delivery" after "care" each time it appears; and

on page 6, in lines 1, 3, 5, 8, 12, 15, 17, 19, 23, 26, 29, and 31, by inserting "delivery" after "care" each time it appears; and

by replacing lines 20 through 22 with the following:
"shall provide charitable care."; and

after line 32, by inserting the following:

"(l) Alternative health care delivery model; birth centers. A birth center is a designated site which is away from the mother's usual place of residence and in which births are planned to occur following a normal, uncomplicated, low-risk pregnancy. A birth center is either freestanding or a distinct part of an ambulatory surgical treatment center or hospital. A birth center shall maintain the ability to transport a patient with complications within 15 minutes under normal travel conditions. The maximum length of stay for patients in a birth center is not to exceed 24 hours unless the treating physician requests additional days from the birth center's medical director on the basis of medical or clinical documentation that an additional care period is required for the recovery of a patient. Reports on variances from the 24-hour limit shall be sent to the Department for its evaluation. The reports shall, before

submission to the Department, have removed from them all patient and physician identifiers. The birth center shall participate in the Illinois Perinatal System. In order to handle cases of complication, emergencies, or exigent circumstances, every birth center as defined in this paragraph shall maintain a contractual relationship, including a transfer agreement, with a hospital at which the physician on staff at the birth center has admitting privileges.

(2) Alternative health care delivery model; postsurgical recovery care center. A postsurgical recovery care center is a designated site which provides postsurgical recovery care for generally healthy patients undergoing surgical procedures that require overnight nursing care, pain control, or observation that would otherwise be provided in an inpatient setting. A postsurgical recovery care center is either freestanding or a distinct part of an ambulatory surgical treatment center, hospital, or skilled nursing facility. The maximum length of stay for patients in a postsurgical recovery care center is not to exceed 72 hours unless the treating physician requests additional days from the recovery center's medical director on the basis of medical or clinical documentation that an additional care period is required for the recovery of a patient. Reports on variances from the 72-hour limit shall be sent to the Department for its evaluation. The reports shall, before submission to the Department, have removed from them all patient and physician identifiers. In order to handle cases of complications, emergencies, or exigent circumstances, every postsurgical recovery care center as defined in this paragraph shall maintain a contractual relationship, including a transfer agreement, with a general acute care hospital."; and

on page 7, in lines 14 and 22, by inserting "delivery" after "care" each time it appears; and

on page 10, in lines 11, 16, and 23, by inserting "delivery" after "care" each time it appears; and

on page 15, in line 28, by inserting "delivery" after "care"; and

by replacing line 34 with the following:

"establish an alternative health care delivery".

APPENDIX F.

ISSUE PAPERS:
BIRTH CENTERS AND RECOVERY CARE CENTERS

BIRTH CENTERS

Introduction

A birth center is a health care facility away from the mother's usual place of residence in which births are planned to occur following a normal, uncomplicated, low-risk pregnancy. The philosophy of birth centers is to provide a setting for low-risk normal births, for which minimal obstetrical or neonatal intervention is required, to occur in an out-of-hospital, home-like environment with comprehensive prenatal care, neonatal care, and follow-up. Usually, there is a high staff-to-patient ratio.

In March, 1991, House Bill 488, the *Birth Center Licensing Act*, was introduced in Illinois' 87th General Assembly, but failed to be passed into law. The bill permitted facilities (except ambulatory surgical treatment centers) to become licensed as birth centers providing prenatal care to women with low-risk pregnancies, and stipulated these facilities must be supervised by a physician with admitting privileges at a hospital in the Illinois Perinatal System. The bill also established a 12 member Birth Center Licensing Board to advise and consult with the Illinois Department of Public Health in its administration of the Act.

Although not its primary purpose, Senate Bill 865 sought to amend the Ambulatory Surgical Treatment Center (ASTC) Act to authorize ASTCs to provide post-surgical or obstetrical care. This bill, which failed, would authorize these ASTCs to render medical care during labor and delivery and stipulate that the ASTCs become integrated into the Illinois Perinatal System. Additionally, it created a board to establish six pilot programs to evaluate the services and to oversee their operation.

Changing trends have led to this legislation. Before the start of the 20th century, almost all births in the United States took place in the home and were supervised by midwives. This trend was subsequently affected by the development of the obstetrics specialty and the corresponding medical education process together with the increasing number of hospitals. By the second half of the century, almost all births took place in hospitals and were primarily supervised by physicians.[1]

Other care-related developments or trends that have influenced the birth process today are: 1) avoidance of drugs and general anesthesia in favor of psychophysical suppression of pain and the use of relaxation techniques; 2) growth in provision of family-centered care; 3) dramatic improvements in technologies to provide better care to women with high-risk pregnancies; 4) inappropriate use of medical technologies such as electronic fetal monitoring; 5) availability of and costs related to professional care, hospital services and insurance coverage; and 6) the increases in malpractice premiums and awards.[1]

In response to these care-related developments, alternatives to traditional environments have developed in the last 20 years. Hospitals have established labor-delivery-recovery-postpartum rooms. Another alternative, out-of-hospital birth centers, is seen as having the benefit of lower cost to consumers and third party payors, and the advantages of choice, control, privacy, and a home-like environment for consumers. The National Association of Childbearing Centers

estimates there are more than 170 centers in the United States today compared with 140 sites in 1986.

To benefit from the experiences of other states, Illinois Department of Public Health staff contacted other state health departments to determine provisions for birth center licensure and to request laws, regulations, and guidelines. Currently, 27 states license birth centers. Overall, most states are considerably permissive with birth center licensure. Statutes and regulations often do not define birth centers or designate high-risk criteria, require transfer agreements, or limit distances from acute care hospitals. The states selected for study generally have the most restrictive licensure requirements: Alabama, California, Florida, Georgia, Iowa, Kansas, Kentucky, Mississippi, Massachusetts, New York, Pennsylvania, and Texas. A detailed description of the birth center requirements in these states is located at the end of this section. The key issues analyzed in these charts are modified from the work of the Alpha Center, 1991. The following paragraphs summarize significant features drawn from the experience of other states.

General Characteristics

All states require a license for birth center facilities in which deliveries take place. However, in California physicians are permitted to routinely provide intrapartum (labor and delivery) care within their own practices without a facility license. Some states require annual inspections and renewal of the birth center license. Most states that require a certificate of need (CON) for other types of health facilities require one for birth centers; of the 12 states studied, five required a CON. Another commonly regulated issue is the length of stay, which ranges from a minimum of four hours in some states to no more than 24 hours in others. State regulations also specify requirements for construction, equipment, laboratories, food facilities, waste disposal, and laundry handling.

Other common requirements include client orientation and informed consent, perinatal screening and counseling, and protocols established and approved by a staff or consulting physician. States limit provider care to low-risk women and require transfer of high-risk women to hospitals for deliveries. The states either specify the distinguishing criteria for determining low-risk pregnancies or reference the criteria established by organizations such as the American College of Obstetrics and Gynecology, the American Academy of Pediatricians and the National Association of Childbearing Centers. Usually the use of anesthesia, drugs, and surgery is prohibited, and many states require a backup facility to be within 30 minutes normal traveling time from birth centers. However, Massachusetts provides for exceptions to these requirements, and Kentucky does not stipulate limitations for use of drugs and anesthesia or the use of a backup facility. Other common requirements include the presence of more than one staff during each delivery and stipulations that each of these staff must be trained in adult and neonatal resuscitation.

The most predominant staffing model is a facility licensed as a birth center in which the certified nurse-midwife provides the primary care and a board-eligible and board-certified obstetrician and pediatrician are consultants. A second model uses the physician as the primary care provider. Texas licenses a third model, a center in which the primary care is provided by a lay midwife.

The locations of birth centers vary. The birth center in Beverly, Massachusetts, a Boston suburb, is on the campus of its back-up hospital, while the birth center in Topeka, Kansas, is a block away from its back-up hospital. Of the two centers in New York City, the center in Manhattan is located in an affluent urban area, while the center in the Bronx serves 250 to 300 persons annually in a low-income neighborhood. The facilities in the Bronx, San Diego, and Fort Lauderdale, Florida are targeted to serve Medicaid recipients. However, the center serving suburban Stuart, Florida, and most other Florida birth centers choose not to accept Medicaid recipients. The Madisonville, Tennessee, birth center opened its doors in December 1983 in a rural setting. The center in Anaheim, located in an old medical office building, was established as a response to the more than 200 women refused service each month at nearby hospitals whose obstetrical services were at overcapacity. This birth center is affiliated with the University of California-Irvine Hospital. While birth centers have been established to serve users in the immediate geographic areas, birth centers such as the one in Rincon, Georgia, attract users from across city, county, and state lines. When users have come from substantial distances to the facility in Beverly, Massachusetts, they temporarily relocate near the birth center several weeks before the expected delivery date.

Most birth centers provide all routine services at the center. However, the center in San Diego has five multidisciplinary teams providing comprehensive perinatal services at eight community clinics in San Diego County, while deliveries are performed at the birth center. Each team is comprises an obstetrician or certified nurse-midwife, a case manager and three other staff who provide nutrition, health education, and psychosocial evaluations as part of a state-certified comprehensive perinatal program. The team members are also bilingual.

Quality of Care

The *Quality of Care* section in the detailed summary demonstrates that the focus of determining quality assurance is measuring process and not outcomes. Since none of the states contacted for additional information has an active data collection and evaluation program, individual birth centers were contacted to determine the outcome evaluations that were readily available. The owner of the San Diego birth center invested personal funds to initiate a pilot study in June 1991. In September 1991, an application was submitted for a million-dollar grant for a four-year program directed by a child health epidemiologist to study the safety and cost effectiveness of an out-of-hospital birth center. The grant is still pending.

The staff of the Madisonville, Tennessee birth center forwarded seven-year cumulative figures for outcomes. This information follows.

MONROE MATERNITY CENTER, INC.
MADISONVILLE, TN
STATISTICS: 12/83 THROUGH 12/90

Indicator	Outcome	Indicator	Outcome
births	599	deaths:	
		perinatal	0
birthweight:	(percent)	neonatal	0
6 to 9 pounds	93.2		
		Apgar Score >6:	(percent)
transfers:	25.2	1 minute	96.5
antepartum	13.2	5 minute	99.3
intrapartum	8.7		
C-Section	4.7	breastfeeding	71.5
neonatal	3.3		
episiotomy	17.0	analgesics in labor	17.0

The Holy Family Services Birth Center in Weslaco, Texas, provided the following information, covering the past five fiscal years:

HOLY FAMILY SERVICES BIRTH CENTER
WESLACO, TX
STATISTICS: FY 1987 THROUGH FY 1991

INDICATOR	1987	1988	1989	1990	1991
births	257	255	261	210	252
infant deaths	0	1	0	0	0
transfers:	(percent)	(percent)	(percent)	(percent)	(percent)
intrapartum	13.5	16.7	16.6	19.8	24.1
neonatal	2.0	1.0	1.0	2.7	1.5
episiotomy	NA	NA	20.0	5.7	7.1
Apgar Score >6:					
1 minute	89.8	91.4	94.6	92.4	94.4
5 minute	99.2	97.6	99.6	99.5	99.6
analgesics in labor	9.0	17.7	9.0	8.4	NA
postpartum and well baby exams 4 to 6 weeks	71.2	74.6	75.1	81.0	84.9
women still breastfeeding at 4 to 6 weeks	66.5	56.5	58.6	59.5	63.1

This birth center primarily serves a low income, minority population. Since fiscal year 1988, more than 91 percent of the mothers seen at the birth center have been Hispanic. Teenagers represented from 17.5 percent to 24.4 percent of the clients during fiscal years 1987 through 1991. In fiscal year 1991, nearly 82 percent of the clients were below 100 percent of the federal poverty level, while 90 percent of the clients were below 132 percent. The birth center is within

20 miles of the back-up hospital and is staffed by certified nurse-midwives under the direction of a consulting physician.

The most recent study on the largest number of birth center users was reported in 1989. *The New England Journal of Medicine* article, "Outcomes of Care in Birth Centers," described the labor, delivery, follow-up care, and outcomes of 11,814 women admitted to 84 birth centers during two and one-half years beginning in mid-1985.[2] Sixty of the centers were operated by certified nurse-midwives, 11 by obstetrician-gynecologists, six by family practitioners or other physicians, three by obstetrician-gynecologists and certified nurse-midwives, and one by a team of certified nurse midwives and lay midwives. The study's findings follow:

- average number of prenatal visits was 11.3;
- CNMs and student CNMs provided care during 78.6 percent of labor and 80.6 percent of births;
- physicians attended 9.9 percent of labors and 16 percent of births;
- 70.8 percent of women and babies had no complications or only complications that posed no inherent risk of death or permanent damage;
- 29.2 percent of the women had more serious complications and emergency complications;
- no maternal deaths occurred among the 11,814 clients; and
- 15 intrapartum or neonatal deaths (1.3 per thousand) occurred (7 were due to the presence of lethal congenital anomalies).

Limitations of the study included the lack of a control group, the fact that data were collected from providers, and the lack of representation by some types of clinics. Intrapartum and neonatal mortality for five centers not included in the analysis was 7.2 per 1,000 births compared with 1.3 per 1,000 births in the study group.[3] However, according to the authors, site visits, sample clinical records, and other methods suggested the data are reliable.

Cost Containment

The cost of perinatal care is increasing nationally. In 1985, an estimated $16.0 billion was spent on maternity and newborn care.[4] This estimate included $4.7 billion spent for physician care and laboratory fees and $11.3 billion for hospital charges. The medical cost averaged $2,900 for normal deliveries and $4,860 for cesarean delivery. The cost of low birthweight infants ranged up to $134,000. In 1988, the upper life-time cost for a low birthweight infant ranged up to $400,000. In 1989, the average hospital charge for a normal delivery to private pay patients in the U.S., not including physician fees, was $2,842[5] compared with $2,165 in Illinois.[6] Neither of these figures includes the charge for newborns. In Florida, the average charge of the 20 birth centers was $2,196, which generally included provider, delivery, and newborn fees.[7]

Summary

The study of the feasibility of birth centers as an alternative health care delivery model is focused on providing a setting for low-risk normal births to occur in a home-like environment with minimal technological intervention and comprehensive prenatal and neonatal care. The model has developed over the last 20 years in response to current trends, with the number of sites growing. Experiences from other states offer guidance in critical areas such as type of licensure, length of stay, hospital back-up, high-risk criteria, reimbursement from the public and private sector, evaluation, and staffing. Alternative settings may include ASTCs or freestanding centers. Length of stay normally ranges from 12 hours to 24 hours or longer. Key issues for consideration and resolution in Illinois include:

- appropriate settings for birth centers; and
- length of stay.

Requirements of Birth Centers in Selected States

The next section summarizes the requirements of birth centers in the states selected for study.

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ALTERNATIVE HEALTH CARE DELIVERY SETTINGS

REQUIREMENTS OF BIRTH CENTERS IN SELECTED STATES

KEY ISSUES	ALABAMA	FLORIDA	GEORGIA	MISSISSIPPI
LICENSURE	• both freestanding and hospital affiliated • waivers may be granted based on hardship, impracticality, or economic infeasibility in complying with rules • no licensed freestanding birth centers	• freestanding • 20 licensed freestanding birth centers	• freestanding • waivers may be granted if rule or regulation is not applicable or to permit new and innovative approaches to delivery of service • one licensed freestanding birth centers	• freestanding; not required for hospital affiliated birth center in same or separate facility as hospital • no licensed freestanding birth centers
CERTIFICATE OF NEED	• required	• not required	• required	• not required
CRITERIA	• patients preacreened for low-risk maternal care • chemical agents not used during 1st and 2nd stage of labor • general and conductive anesthesia not used • center within 30 minutes from a hospital that agreea to 24-hour phone consultation, regular and emergency perinatal services for center's patients	• patients prescreened for low-risk maternal care • general and conductive anesthesia not used	• patients prescreened for low-risk maternal care • chemical agents not used during 1st and 2nd stage of labor • general and regional anesthesia not used • within 30 minutes distance (from initiation of transfer procedure) to obstetric service of referral hospital	• patients prescreened for low-risk maternal care • chemical agents not used during 1st and 2nd stage of labor • general and conductive anesthesia are not used • hospital with level II/III obstetrical service within 30 minutes travel time
SCOPE OF SERVICE	• low-risk maternal care • patient orientation and preparation for childbirth • surgery limited to episiotomy and repair • postpartum exam within 72 hours and 4-6 weeks • child care instruction • family planning	• low-risk maternal care • patient orientation and preparation for childbirth • surgery limited to episiotomy and repair • postpartum exam within 72 hours and 4-6 weeks • child care instruction • family planning	• low-risk maternal care • patient orientation and preparation for childbirth • metabolic screening within week after birth	• low-risk maternal care • surgery limited to episiotomy and repair
LIMITATIONS	• change in low-risk status requires transfer • length of stay (LOS) limited to 24 hours	• change in low-risk status requires transfer • LOS limited to 12 houra	• change in low-risk status requires transfer • LOS limited to 12 hours	• change in low-risk status requires transfer • LOS limited to 24 hours

REQUIREMENTS OF BIRTH CENTERS IN SELECTED STATES

KEY ISSUES	ALABAMA	FLORIDA	GEORGIA	MISSISSIPPI
QUALITY OF CARE	**annual review** of following: • policies, procedures, protocols • peer review-self evaluation • needs of childbearing community **quarterly review** of following: • management of care • all hospital transfers/admissions from center/home during four-week postpartum period • incidence of morbidity and mortality • collection and analysis of data • infections **annual quality assurance report** to state	**quarterly review** by clinical staff of the following: • management of care • all hospital transfers • incidence of morbidity and mortality • infectiona • documentation **semi-annual reports** on above items by quality assurance committee; reports reviewed by governing body	• **quarterly review** of morbidity and mortality data; annual report submitted to state	• **periodic record** review and documentation • recommends center to have committees to facilitate the establishment and attainment of goals and objectives of nursing service and the birth center • in-service training and minimum of 16 hours of approved continuing education annually in addition to CPR and infant resuscitation • annual participation in staff development • **annual** community needs assessment optional
STAFFING	• **administrator:** (qualifications not specified) manages, controls and operatea the center • **director:** same qualifications as primary care giver or consultant; responsible for facility programs • **consultant:** required for birth center without staff physician who is ABOG/ABOOG certified/eligible; 1) licensed MD; 2) ABOG/ABOOG certified/eligible or approved by state health department • **primary care giver:** licensed physician **OR** licensed RN who is state and ACNM certified as midwife and has a year's experience in labor and delivery and/or newborn intensive care • **RN:** licensed with year of obstetrical experience	• **director:** (qualifications and responsibilitiea not specified) • **clinical director:** (qualifications and responsibilities not specified) • **consultant:** required for birth center without staff physician who is ABOG/ABOOG certified/eligible and: 1) licensed; 2) ABOG/ABOOG certified/eligible **OR** has hospital obstetrical privileges • **primary care giver:** licensed physician, **OR** licensed certified nurse midwife **OR** licensed midwife • **second care giver:** must be present • one clinical staff member for every two clients in labor	• **administrator:** (qualifications not specified); responsible for day to day management • **medical director:** physician; responsible for professional aspects of center's programs • **physician:** 1) licensed; 2) board eligible/certified in obstetrics, family practice or pediatrics; 3) admitting privileges at backup hospital **OR** agreement with hospital staff physician to provide services at backup hospital • **primary care giver:** licensed physician **OR** licensed RN certified by ACNM and at center available for assistance to patient during labor delivery, and immediate postpartum stages • **second care giver:** must be present and may be any health professional who requires special licensure, certification or registration • minimum of one physician/CNM/RN/LPN in facility when patient present	• **administrator:** (qualifications not specified); manages/controls/operates center services • **designated director:** physician or nurse midwife; provides direction and coordination of facility programs • **director of nursing:** with one year of obstetrical nursing experience; responsible for developing/implementing policies and procedures for nursing staff • **primary care giver:** physician/certified nurse midwife; at center during any active labor at staff/patient ratio of 1:2 • **physician:** license MD/DO with one year of obstetric experience • **CNM:** licensed RN; state certified midwife with year of labor/delivery/newborn intensive care experience • **RN:** licensed; with one year of obstetric experience at 1:2 staff/patient ratio for first two patients; more patients require additional RNs • **LPN:** with one year of experience in obstetrics • minimum of two health care providers trained and certified in CPR and infsnt resuscitation attending each birth

ALTERNATIVE HEALTH CARE DELIVERY SETTINGS

REQUIREMENTS OF BIRTH CENTERS IN SELECTED STATES

KEY ISSUES	ALABAMA	FLORIDA	GEORGIA	MISSISSIPPI
LINKAGE AND REFERRAL AGREEMENTS	• **consultant:** to provide advice and services as requested • **hospital:** within 30 minutes with obstetrician and pediatrician on staff and 24-hour emergency care and caesarean section capability	• **consultant:** to provide advice and services as requested; if unable to enter into consultation agreement, center may request such service from the state agency	• **hospital:** to provide emergency obstetrical care • **ambulance service:** to assure emergency transportation in timely manner	• **hospital:** with Level II/III obstetrical service to provide obstetrician and pediatrician for transferred patients • **transportation:** for the transfer of patients to hospital
ACCREDI-TATION	• recommended	• not specified	• not specified	• encouraged
REIMBURSE-MENT	• not available	1989 information: • 7 of 19 birth centers accepted Medicaid • 54 percent of birth center deliveries were at centers that accept Medicaid	• less than 10 percent of physicians accept Medicaid	• not available
DATA COLLECTION AND EVALUATION	• quarterly - statistical; • prescribed for detail regarding use of all services, before, during and after delivery	• not specified	• system to collect, process, maintain, store and retrieve patient health service information, including individual patient records	• required for services provided and outcomes
LIABILITY COVERAGE	• minimum of $1 million by each professional staff and each consultant	• not specified	• not specified	• professional staff and consultants to provide evidence of malpractice insurance coverage OR inform clients that they do not carry malpractice insurance
COST CONTAINMENT	• not available	average cost (1989) for normal pregnancy and delivery in Florida: • $2587 for hospitals (does not include physicians fees) • $2196 for birth centers (generally includes all fees)	• not available	• not available

ALTERNATIVE HEALTH CARE DELIVERY SETTINGS

REQUIREMENTS OF BIRTH CENTERS IN SELECTED STATES

KEY ISSUES	CALIFORNIA	MASSACHUSETTS	NEW YORK	PENNSYLVANIA
LICENSURE	• "special service" clinic • three licensed "special service" clinics	• freestanding (clinic license) • hospital affiliated (hospital license) • two licensed freestanding birth centers	• freestanding • two licensed freestanding birth centers	• freestanding • six licensed freestanding birth centers
CERTIFICATE OF NEED	• not required	• not required	• required	• not required
CRITERIA	• patients prescreened for low-risk maternal care	• patients prescreened for low-risk maternal care • chemical agents not used during 1st and 2nd stage of labor • general and conductive anesthesia are not used • physicians (staff and consultant) must have staff privileges at parent or nearby[1] hospital; **HOWEVER** distance requirement may be waived if center in defined geographically isolated area and nurse midwives trained to perform neonatal resuscitation	• patients prescreened for low-risk maternal care • chemical agents not used during 1st and 2nd stage of labor • general and regional anesthesia are not used • referral hospital within 20 minutes from center	• patients prescreened for low-risk maternal care
SCOPE OF SERVICE	• low-risk maternal care • child care instruction • family planning information and education • prompt follow-up infant and maternal care • assessment of mother-child relationship • referral to aftercare	• low-risk maternal care • surgery limited to episiotomy and repair • follow-up examinations within 72 hours after birth	• low-risk maternal care • childbirth and infant care education classes • surgery limited to episiotomy and repair • first home visit by center staff within 24 hours after discharge • second home visit by center staff within three days after discharge • follow-up visit at center 2 and 6 weeks after discharge	• low-risk maternal care • aftercare referral for mother and infant
LIMITATIONS	• change in low-risk status requires transfer • length of stay (LOS) not specified	• change in low-risk status requires transfer • LOS limited to within 24 hours after birth	• change in low-risk status requires transfer • required LOS from 4 to 24 hours after completion of third stage of labor	• change in low-risk status requires transfer • LOS not specified

REQUIREMENTS OF BIRTH CENTERS IN SELECTED STATES

KEY ISSUES	CALIFORNIA	MASSACHUSETTS	NEW YORK	PENNSYLVANIA
QUALITY OF CARE	**quarterly review** by director and perinatal committee of: • existing and needed patient services and procedures • patient records • quality assurance activities • APGAR scores • outcomes of mothers and infants • continuing education/in-service training required for all staff in: family centered birthing, prenatal, interpartum postpartum care physical assessment of mother and infant; annual review of skills in infant and adult resuscitation,	• review and evaluation of medical and social risk criteria quality and appropriateness of care; documentation of reviews	• joint hospital/center review of transfers that are documented	• policies and procedures consistent with professional standards of ACNM, ACOG and AAP • regular inservice training in areas of medication, patient education and normal patterns and complications of pregnancy • outservice training opportunities offered • **semiannual review** of records of mothers and newborns • **annual review/revision/approval** of transfer criteria and personnel policies
STAFFING	• **professional director:** responsible for protocols, services, credentialing, quality assurance and peer reviews, and delineating clinical privileges • **medical services director:** licensed physician ABOG certified/eligible with hospital privileges in obstetrics responsible for medical services (may be professional director) • **consultant:** (not specified) • **primary care giver:** physician "with current knowledge and specific training in obstetrics and newborn care"/CNMs/PAs supervised by certified PA supervisors • **second care giver:** minimum of RN with current knowledge and specific training in maternity and newborn care • **RN:** licensed, responsible for nursing services (if exception approved, then licensed vocational nurse with RN as consultant) • staff providing direct patient care must be supervised by physician or RN • physician/physician assistant/RN present when medical services provided	• **director:** certified nurse midwife, obstetrician **OR** family practitioner with obstetrical privileges in parent/nearby[1] hospital; responsible for operation and maintenance of center • **director of medical affairs:** board eligible/certified obstetrician/gynecologist with full obstetrical privileges at parent/nearby[1] hospital; responsible for advising and consulting on medical matters including policies/procedures/protocols for midwifery management of care • **consultants:** (see LINKAGE\REFERRAL AGREEMENTS: CONSULTANT below) • **primary care giver:** certified nurse midwife, obstetrician **OR** family practitioner with obstetrical privileges at parent/nearby[1] hospital • **second care giver:** nurse midwife **OR** licensed nurse with labor and delivery experience within one year of employment in a licensed obstetrical service and received prescribed training	• **medical director:** specialist in obstetrics/gynecology **OR** family practice; admitting privileges for maternity patients at transfer hospital(s) **OR** formal arrangements for obstetrical care; provides medical supervision and consultation of patients • **director of nurse midwifery services:** (no qualifications specified) supervises nurse midwives • **consultant:** specialist in pediatrics/family practice with admitting privileges at referral hospital(s) • **primary care giver:** obstetrician/family practitioner/nurse midwife; at center during any active labor staff birth • **second care giver:** specially trained in labor and delivery technique and care of newborn • minimum of two staff trained in emergency procedures on duty when a mother and newborn are at center	• **medical director:** licensed physicisn • **consultant:** obstetrician/pediatrician when medical director is not such • **primary care giver:** physician/midwife must be present during labor • **physician:** licensed MD/DO • **midwife:** nurse certified as midwife by the state • licensed **RN** • **LPN**

ALTERNATIVE HEALTH CARE DELIVERY SETTINGS

REQUIREMENTS OF BIRTH CENTERS IN SELECTED STATES

KEY ISSUES	CALIFORNIA	MASSACHUSETTS	NEW YORK	PENNSYLVANIA
LINKAGE AND REFERRAL AGREEMENTS	• **emergency medical transportation**	• **consultant:** board eligible/certified obstetrician/gynecologist **AND** pediatrician or neonatologist with full privileges at parent/nearby[1] hospital to provide 24 hour consultation referral and transfer for obstetric/newborn care • **parent/nearby[1] hospital:** to provide emergency obstetrical and newborn services	• **hospital(s):** to provide for admission of mother/infant	• **consultant:** obstetrician/pediatrician to provide those specialty services when physician director not obstetrician/ pediatrician • **physician:** with admitting privileges for mother/newborn to hospital • **emergency transportation:** to transport mother/newborn to hospital
ACCREDI-TATION	• not specified	• not specified	• not specified	• not specified
REIMBURSE-MENT	• all three freestanding birth centers eligible for Medicaid	Medicaid rates for comprehensive care: • $1781 physician • $1736 for certified nurse midwife	• not available	• not available
DATA COLLECTION AND EVALUATION	• not specified	• not specified	• not specified	• prescribed statistical data to submitted to state health department
LIABILITY COVERAGE	• not specified	• not specified	• not specified	• not specified
COST CONTAINMENT	• not available	• not available	• not available	• not available

1 = within 10 minutes driving time

REQUIREMENTS OF BIRTH CENTERS IN SELECTED STATES

KEY ISSUES	IOWA	KANSAS	KENTUCKY	TEXAS
LICENSURE	• freestanding • no licensed freestanding birth centers	• freestanding • one licensed freestanding birth center	• freestanding • no licensed freestanding birth centers	• freestanding: 1) service provided by physician/CNM; OR 2) service provided by lay midwife • fifty licensed freestanding birth centers: 1) 10 at which service is provided by physician/CNM; 2) 40 at which service provided by lay midwife
CERTIFICATE OF NEED	• required	• not required	• required	• not required
CRITERIA	• patients prescreened for low-risk maternal care • chemical agents not used during 1st and 2nd stage of labor • general and conductive anesthesia not used	• patients prescreened for low-risk maternal care • level II/III hospital within 30 minutes travel time (including time for ambulance to arrive at center) • completion of child birth preparation course requirement for admission for delivery • references criteria listed on pages 53 and 54 of the 1983 edition of the "Guidelines for Perinatal Care," issued by AAP and ACOG	• patients prescreened for low-risk maternal care according to ACOG's Standards for Obstetric-Gynecologic Services, as amended • medical director, consultant obstetrician OR pediatrician with admitting privileges in local hospital that offers obstetric services • minimum of two birth rooms	• patients prescreened for low-risk maternal care • general, epidural and subdural anesthetic not used • referral hospital within 30 minutes from center unless state determines this requirement to be unreasonable • consultant required to be present to deliver emergency care within 30 minutes;
SCOPE OF SERVICE	• low-risk maternal care • patient orientation and preparation for childbirth • surgery limited to episiotomy and repair • prompt follow-up infant and maternal care • child care instruction • family planning • assessment of mother-child relationship • referral to pediatric care	• low-risk maternal care • first home visit by licensed health professional on center staff within 24 hours after discharge • second home visit by licensed professional on center staff within three to four days • visitors screened for communicable disease	• low-risk maternal care • follow-up assessment within 72 hours • four to six-week follow-up examination • referral to physician for aftercare	• low-risk maternal care • mechanical or chemical assistance not used for delivery • aftercare referral for mother and infant
LIMITATIONS	• change in low-risk status requires transfer • length of stay (LOS) limited to 12 hours	• change in low-risk status requires transfer • required LOS 6 to 24 hours after delivery	• change in low-risk status requires transfer • LOS not specified	• change in low-risk status requires transfer • required LOS 6 to 24 hour after delivery

REQUIREMENTS OF BIRTH CENTERS IN SELECTED STATES

KEY ISSUES	IOWA	KANSAS	KENTUCKY	TEXAS
QUALITY OF CARE	• assessment of transportation protocols and services • **quarterly review** of morbidity and mortality data • **semiannual review** of referrals and transfers	• not specified	• not specified	**quarterly review** of: • clinical records • incidence of morbidity and mortality • infections • all transfers • exceptions to 24-hour stay requirement due to medical reasons • other incidents, problems and potential problems identified by staff • problems with compliance with state laws • procedures concerning drugs and biologicals
STAFFING	• **director:** licensed physician/nurse midwife/or other (if other, then a director of midwifery servicea ia appointed); responsible for operations and maintenance • **clinical director:** licensed or certified to provide care at childbirth; advisea and consults with staff • **consultant:** ABOG certified/eligible **OR** has hospital obstetrical privileges and requires two prenatal visits with each patient • **primary care giver:** licensed physician/ nurse midwife	• **advisory board:** minimum of five members including one licensed phyaician **and** one licensed RN • **director:** (qualificationa not specified) responsible for administrative operation and compliance to state law • **consulting obstetrician** and **pediatrician:** ABOG and ABP eligible **and** both must have full staff privileges in level II or level III hospital • **physician:** licensed with staff privileges in hospital and responsible for delivery of infants • **nurse midwife:** licensed and ACNM certified • **registered nurse:** licensed with one year of obstetrics experience in an accredited hospital • **educator:** teaching certificate for providing childbirth preparation instruction • second nurse required if more than one patient in labor	• **administrator:** (qualifications not specified) responsible for daily operation and management • **medical director:** licensed physician experienced in obstetrics and newborn care • **consultants:** if medical director not board eligible/certified obstetrician, then two physicians required - board eligible/certified obstetrician and pediatrician; **OR** if medical director is a practicing obstetrician or board eligible/certified obstetrician, then only one physician required - board eligible/certified pediatrician • **primary care giver:** obstetrician **OR** nurse midwife **AND** RN at center when pregnant women in labor • **second care giver:** RN with one year of experience in perinatal care	• **administrator:** (qualifications not specified) responsible for implementing policies, programs and services • **clinical director:** physician\CNM\lay midwife (see LICENSE above), advises/ consults center staff regarding patient management • **consultant:** licensed physician should be board eligible/certified obstetrician/ pediatrician; approves risk assessment system; has admitting/attending privileges at nearby hospital; capable of providing or securing high-risk obstetric and newborn services • **primary care giver:** physician/CNM/lay midwife trained in the use of emergency equipment and certified in cardiopulmonary and infant resuscitation • **physician:** licensed MD/DO • **CNM:** licensed RN/advanced nurse practitioner and ACNM certified • **lay midwife:** as defined by state law

REQUIREMENTS OF BIRTH CENTERS IN SELECTED STATES

KEY ISSUES	IOWA	KANSAS	KENTUCKY	TEXAS
LINKAGE AND REFERRAL AGREEMENTS	• **consultant:** to provide medical and obstetrical advice and services • **ambulance service:** to provide emergency transportation if birth center does not own or operate ambulance; both ground and air ambulance to provide neonatal specific transportation services	• **obstetrician** and **pediatrician:** responsible for the emergency transfer of patient to a hospital • **hospital:** with level II/III care • **ambulance:** to provide emergency transfer of patients stipulating type of service and transfer time	• **hospital(s):** to supplement services available at center • **consultant:** to provide consultation/referral/ hospital admission • **transport services:** to provide appropriately equipped emergency medical transportation	(not specified)
ACCREDI-TATION	• not specified	• not specified	• not specified	• not specified
REIMBURSE-MENT	Medicaid rates: • $445.50 for prenatal care • $702 for delivery • $202.50 for postpartum care	• not available	Medicaid rate: • $365 for normal delivery	• not available
DATA COLLECTION AND EVALUATION	• not specified	• not specified	• not specified	• not specified
LIABILITY COVERAGE	• not specified	• liability and casualty insurance for the facility • prescribed minimum liability coverage for ambulance service	• not specified	• not specified
COST CONTAINMENT	• not available	• not available	• not available	• not available

RECOVERY CENTERS

Introduction

One of the newest concepts in alternative health care delivery is the recovery center. Typically designed to provide postsurgical recovery care (PRC), such centers offer an alternative to hospitalization for generally healthy patients undergoing surgical procedures requiring a short recovery period exceeding 24 hours, but usually less than three days.

In some states, postsurgical recovery care is coupled with delivery of subacute care, and the two concepts are sometimes confused. While a March 1988 study by the Florida Hospital Cost Containment Board determined no universal definition of subacute care exists,[1] it is generally described as a level of care *above* skilled nursing and intermediate care but *below* acute care. It is commonly considered appropriate for medically stabilized patients who are recovering from acute care episodes and no longer require the intensity of care provided in acute care settings, but are too medically fragile to be discharged to a nursing home. In addition, subacute care is typified by a considerable length of stay in comparison with postsurgical recovery care.

Postsurgical recovery centers are promoted as an attractive alternative for a variety of reasons, including the relaxing, private, home-like atmosphere they often incorporate in facility design; the encouragement of active participation by family or friends as "care partners" that is characteristic of several models; and the high nurse-to-patient ratio they frequently offer. Most interest in the concept, however, has centered on their reported potential to reduce health care costs while maintaining quality of care.

Interest in studying the feasibility of postsurgical recovery care (PRC) centers as an alternative mode of health care delivery surfaced in the Illinois legislature during previous sessions. In Illinois' 87th General Assembly, two bills were introduced: House Bill 2590 and Senate Bill 865. House Bill 2590 established a pilot project for determining the feasibility of authorizing medical payment for PRC centers for periods generally not exceeding three days at Ambulatory Surgical Treatment Centers (ASTCs). Senate Bill 865 provided for a similar pilot project for ASTCs providing postsurgical *and* obstetrical care under a 72-hour restriction on length of stay. Both bills created definitions for these new types of facilities that were operative only for the life of the pilot projects, and both created temporary boards to oversee the pilot centers and to report evaluations and recommendations to the Director of Public Health and other appropriate parties. Neither bill passed in its respective house.

Because the emphasis of these bills was on postsurgical recovery care rather than subacute care, PRC is the focus of this discussion. Illinois Department of Public Health staff conducted a phone survey of health facility regulators in every state in an attempt to determine the licensure and regulatory status of postsurgical recovery care centers throughout the nation. Concurrently, a review of existing literature on recovery care produced a list of health department personnel, providers, association executives, and others in selected states active in studying, regulating, or promoting postsurgical recovery care. Information provided by these contacts, in combination with the existing literature, is presented in summary charts at the end of this section for California, Texas, Arizona, Connecticut, Florida, Colorado, and Rhode Island. The key issues

selected for analysis in the charts are modified from the work of the Alpha Center, 1991.[2] The following discussion summarizes significant features and critical issues drawn primarily from the experience of these states.

General Characteristics

No state currently recognizes postsurgical recovery care centers as a licensure category. Several states are in the process of studying this issue, however, and state regulatory staff and facility administrators in Arizona expect licensure for recovery care facilities to become a reality during their next legislative session.

The fact that PRC centers are not yet a recognized licensure category does not mean that centers are not operating or regulated. In Arizona, the first such facility, the Surgical Recovery Care Center, opened its doors in 1979. For 13 years it has been licensed as an "Unclassified Health Care Facility." Licensure in Texas has taken a different route. PRC centers in that state are licensed as "Special Rehabilitation Hospitals," and must meet related regulatory requirements. The New Haven Medical Hotel operates without licensure in Connecticut at present because it is defined as a non-medical entity. The Hotel, itself, provides accommodations, but no medical treatment. California became the first state to legislatively authorize postsurgical recovery care through a demonstration project of up to 13 PRC pilot sites that are unlicensed for the duration of the project. In all cases where PRC centers are regulated, those regulations specify standards for nursing, pharmacy, dietary, waste disposal, laundry and housekeeping, equipment and construction, and any optional services offered such as radiology.

Other states (Colorado, Georgia, Alabama, North Carolina, and Connecticut) are attempting to study or regulate PRC centers through extensions of their ambulatory surgical center (ASC) acts or nursing home rules and regulations. In Virginia, certificate of need applications have been submitted for PRC programs using general acute care hospital beds. Like Illinois, Florida has considered legislation authorizing pilot projects, but its legislature did not pass the proposed bill. Rhode Island has gone so far as to draft rules for freestanding recovery care facilities.

Not surprisingly, postsurgical recovery care is often introduced in a state as an extension of the ASC concept. Perhaps this occurs because of one significant feature the two settings share--planned admissions. The target population for postsurgical recovery care is that group of low-risk patients scheduled for surgery that would normally require them to remain at least overnight in an inpatient setting if PRC facilities were not available. Generally, these patients are healthy, require a surgical procedure in general anesthesia class I or II, and their prognosis is for a short postsurgical recovery.[3] As an example, admissions are often patients undergoing elective procedures, with recovery care for cosmetic surgery patients providing the initial impetus for development of the PRC concept in Arizona. PRC centers would not receive patients who are referred currently for ambulatory or outpatient surgery because the recovery period required by these patients would be less than 24 hours.

ASC regulations usually limit length of stay (LOS) to a specified number of hours (some states to 12 hours or less) and in many cases, as in Illinois, prohibit "overnight stay." This constraint considerably restricts the types of procedures that may be performed in an ASC. By removing

overnight stay prohibitions and extending the maximum LOS to at least 24 hours, some states are expanding the scope of services ASCs can provide. When LOS limitations are extended past 24 hours for associated PRC centers, the range of appropriate procedures for ASCs increases even further.

Generally, although not always, LOS limitations characterize PRC regulations. These limitations vary from state to state, with 48 hours the current norm. The California demonstration project and the draft Rhode Island regulations require admissions to be planned according to one LOS criterion, but will allow a limited extension if explicit documentation for the extended LOS is provided. The Illinois legislation as originally proposed followed this model as well.

Appropriate LOS has become a controversial issue in the field of PRC. When LOS limitations for PRC centers exist, patients may be transferred to inpatient hospital settings during the last few hours of care before discharge if the LOS limit is about to be exceeded. Some experts have suggested that a list of the types of procedures most appropriate for recovery in a PRC center would provide a better admissions criterion than expected LOS. This list might vary geographically, as does average LOS for procedures, based upon the population and practice patterns in a particular area.[3] A shortcoming of this approach is that adding new procedures to the list would require changes in regulation or a process of administrative review.

Regulations governing most PRC centers operating in the nation require a physician to serve as Medical Director, a staff physician to be on call for emergencies at all times, a registered professional nurse to serve in a full-time capacity as Director of Nursing, and nursing personnel to be on duty whenever patients are present.

Postsurgical recovery care is delivered in a variety of settings, including centers attached to freestanding ambulatory surgery centers (ASCs), those operating as distinct parts of skilled nursing facilities or acute care hospitals, and freestanding centers that receive postsurgical patients transferred by ambulance from freestanding ASCs and hospitals. Usually some type of linkage or referral agreement with an acute care facility exists. Sometimes these take the form of written transfer procedures to govern both scheduled and emergency transfers or requirements that all physicians on the medical staff have admitting privileges at local hospitals. In other cases, the relationship is more direct. The Hospital of Saint Raphael is a *partner* with the Temple Medical Center, an ASC, in the development of the New Haven Medical Hotel, for example.

The California demonstration project and legislation introduced in both Florida and Illinois place conditions on the number and location of pilot PRC sites to insure that both urban and rural areas throughout these states are potentially represented in data collection and evaluation studies.

Quality of Care

Accreditation for PRC facilities is available on a voluntary basis from the Accreditation Association for Ambulatory Health Care, Inc. The Association recently added standards for overnight care to its *Accreditation Handbook for Ambulatory Health Care*.

Regulations for PRC centers primarily deal with the *process* of reviewing and insuring quality of care and not with *outcomes*. Consequently, the majority of information about PRC center outcomes is anecdotal. The California demonstration project provides a notable exception, in that the regulations governing this project specifically address data reporting requirements. The Request for Proposals issued by the California Office of Statewide Health Planning and Development (COSHPD) for the project offers even greater specificity with respect to outcome measures.

The evaluation report from the COSHPD is due six months prior to the scheduled end of the demonstration, which has been extended to September of 1994. Data summaries, including types of procedures performed; number of cases, length of stay, and charges for each procedure; age, race and sex distribution of patients; reimbursement sources; and documentation of extended stay cases are periodically published by the COSHPD. Information about outcomes at individual facilities participating in the California demonstration and at PRC centers in other states have been reported in the literature; most indicate patient stays generally free of complications and minimal referrals to acute care hospitals. This reported result should not be surprising since the California demonstration project standards for nurse staffing in PRC centers are the same as those for hospitals. In addition, PRC admissions target a generally healthy population.

Cost Containment

The ability to deliver quality care while containing costs is an argument widely employed in promoting the PRC concept. The literature suggests that the cost savings in using PRC centers as an alternative to inpatient hospital care ranges from 25 percent to 40 percent,[4] with many sources reporting 30% as an average savings estimate.

State hospital associations have traditionally opposed the authorization of PRC centers based on concerns that the centers would "skim" the healthiest and best-paying patients from the hospital setting. They have argued that losing the ability to shift costs to patients covered by third-party payors would severely burden their members who are already saddled with the responsibility of providing care to Medicaid, Medicare, and indigent patients, and would result in increased costs for hospital inpatient care as fixed costs must be spread over fewer patients. The result, in their view, would be no net savings to the health care delivery system.

Reimbursement sources for PRC centers differ from traditional hospital settings. At present, Medicare does not reimburse PRC centers, and few state Medicaid or Blue Cross and Blue Shield plans do. Until PRC centers can actually qualify for reimbursement from the same sources as hospitals, an effective evaluation of their impact on costs--to their patients as well as the health care delivery system as a whole--is difficult.

Without licensure, PRC centers are cannot be certified for either Medicare or Medicaid reimbursement,[5] and many insurance plans will not cover services delivered in an unlicensed facility. This feature of the California demonstration project prevents PRC centers from eligibility for reimbursement from either Medicare or Medicaid should the required waivers be obtained during the life of the demonstration project. In Connecticut, problems with third-party

reimbursement due to lack of licensure have led the New Haven Medical Hotel to seek licensure through an extension of the nursing home rules and regulations.

To lend support to a movement to persuade the federal government to conduct a Medicare demonstration project of PRC centers, the National Recovery Care Association commissioned a study of the cost effectiveness of recovery care for Medicare patients. Conducted by Lewin/ICF of Washington, D.C., the study used data from the Surgical Recovery Care Center in Phoenix and the Sharp Post Surgical Recovery Center in San Diego to compare the Medicare DRG payment with the cost for treating like patients in a freestanding surgery center and recovery center. Preliminary summary results indicated significant cost savings would occur if appropriate utilization controls were put into place.[6] However, concerns about extrapolating the results to the entire Medicare population, since the study sample was small, have led to an expansion of the study to include a facility in Houston, Texas, and the New Haven Medical Hotel in Connecticut. Results of the expanded study are not yet available.

Most additional information about the ability of PRC centers to contain costs is anecdotal. While individual facilities report cost savings to payors through use of PRC centers as an alternative to hospitals, more research into the impact of PRC centers on the costs to the entire health care delivery system is critical.

Summary

The study of the feasibility of recovery care as an alternative health care delivery model in Illinois is focused on postsurgical recovery care of short duration for generally healthy patients. While the experiences of other states in this relatively new delivery mode are limited, they do provide meaningful and generally consistent guidance in areas such as scope of services, staffing, and linkage and referral agreements, as well as critical lessons in areas such as licensure status and reimbursement. For example, it is clear that to maximize the potential for reimbursement for this type of care, licensure will be a necessary component of any Illinois demonstration project.

Key issues that require careful consideration and resolution in the design of a worthwhile Illinois pilot are:

- the appropriate settings for delivery of such care; and
- the fundamental criterion for admissions planning.

Settings that may be considered include centers attached to freestanding ASTCs, those operating as distinct parts of skilled nursing facilities or acute care hospitals, and freestanding centers that receive postsurgical patients transferred from freestanding ASTCs and hospitals. The fundamental criterion for admissions planning may be based upon types of procedures or length of stay. If length of stay is selected as the fundamental criterion, the maximum number of hours must be defined and any means for extensions identified. These decisions are imperative to the design of an effective pilot project to evaluate the impact of postsurgical recovery care centers in Illinois.

Dimensions of Postsurgical Recovery and Subacute Care Centers in Selected States

The following section depicts the key dimensions of postsurgical recovery and subacute care centers in selected states.

References

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DIMENSIONS OF POSTSURGICAL RECOVERY AND SUBACUTE CARE CENTERS IN SELECTED STATES

KEY ISSUES	CALIFORNIA	TEXAS	ARIZONA	CONNECTICUT
LICENSURE	• unlicensed	• licensed as Special (Rehabilitation) Hospitals	• licensed as Unclassified Health Care Facilities • new licensure classification for recovery care centers is currently being proposed	• currently exploring licensure through an extension of the nursing home rules and regulations • New Haven Medical Hotel originally deemed exempt from licensure because facility was defined as a non-medical entity
CERTIFICATE OF NEED	• not applicable	• not applicable	• not applicable	• New Haven Medical Hotel, although a non-medical entity, received a certificate of need
CRITERIA	*Postsurgical Recovery Care Facility*: • one of 13 designated demonstration project sites, each containing 20 beds or less, that is either freestanding or a distinct part of a licensed health facility • if part of licensed health facility, cannot (1) be located in the service area of freestanding sites; or (2) have a service area that overlaps with the service areas of freestanding sites	*Rehabilitation Hospital*: • a special hospital that provides rehabilitation servicea • an establishment offering services, facilities and beds for use beyond twenty-four hours for two or more nonrelated individuals who are regularly admitted, treated and discharged and require services more intensive than room, board, personal services and general nursing care	*Unclassified Health Care Facility*: • a facility that is clearly a health care institution, but does not come within any of the following subclasses: • hospitals, including general, special or rural general • nursing care institutions, including skilled nursing care facilities, intermediate care facilities, and personal care facilities • outpatient treatment centers, including outpatient surgical centers, emergency treatment clinics, outpatient treatment clinics and health services clinics • residential care institutions, including supervisory care homes • home health agencies • infirmaries • behavioral health service agencies	*New Haven Medical Hotel*: • cooperative venture between an ASC, Temple Medical Center, and Hospital of St. Raphael • designed to serve as a bridge between hospital and home • non-hospital setting offering hotel-like accommodations and the services of health professionals on premises • accepts transfers from hospital or expanded surgical unit as well as direct admissions

ALTERNATIVE HEALTH CARE DELIVERY SETTINGS

DIMENSIONS OF POSTSURGICAL RECOVERY AND SUBACUTE CARE CENTERS IN SELECTED STATES

KEY ISSUES	CALIFORNIA	TEXAS	ARIZONA	CONNECTICUT

SCOPE OF SERVICE	• postsurgical recovery care
	• ancillary service(s):
	  • pharmaceutical
		• postsurgical recovery care
		• subacute care
		• ancillary services:
		  • clinical laboratory facilities (may contract with a Medicare approved outside laboratory)
		  • portable X-ray equipment or arrangements for such equipment
		  • physical therapy facilities and equipment adequate to meet the needs of those patients requiring physical therapy
		  • pharmacy (optional)
			• Surgical Recovery Center, Inc. in Phoenix offers:
			  • postsurgical recovery care
			  • post-hospital care (subacute)
			  • medical care
			  • ancillary services unspecified
				• New Haven Medical Hotel offers:
				  • postsurgical recovery care
				  • subacute care
				  • respite care
				  • accommodations for patient-guests and "care partners"
				  • emergency backup services through an onsite Concierge/EMT
				  • special services, including recreational, educational, personal and pharmacy services
				  • twenty-four hour nursing services through an onsite home health care agency
				  • ancillary services through the adjoining Temple Medical Center:
				  • laboratory
				  • physical therapy
				  • radiology

LIMITATIONS	• 48 hours length of stay (LOS) planned, but limited to not more than 72 hours • accepts only preplanned admissions of persons one year of age or older who have had outpatient surgical procedures performed and (1) who will need to stay at least overnight but not more than 48 hours at the facility; and (2) whose condition would require them to be cared for on an inpatient basis if postsurgical recovery care facilities did not exist	• minimum LOS of more than 24 hours; no maximum • unlike general hospitals, not required to maintain emergency department	• currently no limitations on types of admissions or LOS • limit on LOS in proposed legislation has been deleted	• no specified limitations on types of admissions or LOS • basic principle: combined LOS at hospital and hotel will not exceed existing hospital average LOS • unlike a regular hotel, at New Haven Medical Hotel, patients are admitted and discharged by their physicians

DIMENSIONS OF POSTSURGICAL RECOVERY AND SUBACUTE CARE CENTERS IN SELECTED STATES

KEY ISSUES	CALIFORNIA	TEXAS	ARIZONA	CONNECTICUT
QUALITY OF CARE	• quality assurance (QA) program implemented by a QA Committee composed of the Administrator, Medical Director, Director of Nursing, two physicians from participating surgery programs and a staff nurse • QA committee must adopt written procedures • specific tasks of the QA Committee include: (1) identifying and reviewing the records of all patients requiring a third day of care; (2) reviewing within 72 hours all patient cases where medical emergencies or deaths occur and submitting to the State a written report of their findings in such cases; and (3) reviewing the availability of resources necessary to respond to medical emergencies • written policies and procedures for patient care must be developed and maintained, and if the facility plans to treat pediatric patients, must specifically address the care of these patients	• no formal QA program is required	• no formal QA program is required	• no formal QA program is required

DIMENSIONS OF POSTSURGICAL RECOVERY AND SUBACUTE CARE CENTERS IN SELECTED STATES

KEY ISSUES	CALIFORNIA	TEXAS	ARIZONA	CONNECTICUT
STAFFING	• medical staff is composed of Medical Director (physician) and all physicians, podiatrists and dentists with admitting privileges at facility • staff physician must be on call for emergencies at all times • Director of Nursing must be on an eight hours a day, five days a week schedule • at least two licensed nurses must be on duty at all times patients are present, one of whom must be a registered nurse certified for advanced cardiopulmonary life support • all nursing staff must: (1) be certified for basic cardiopulmonary life support; and (2) have a minimum of two years experience within the last five years in the post anesthesia recovery unit or medical/surgical unit of an acute care hospital or in an outpatient surgery center • must have consultant pharmacist and consultant registered dietitian	• medical staff is composed of a Chief of Staff (physician) and all physicians, podiatrists and dentists appointed by the governing board • one or more physicians must be on call at all times for emergencies • Director of Nursing Services, a registered professional nurse, must be on duty or on call at all times • a registered professional nurse must be on duty at least eight hours between the hours of 7 a.m. and 6 p.m. • licensed nursing service must be available for all patients at all times • if provided, diagnostic radiological service must be under the supervision of a qualified radiologist, licensed physician, or radiology committee of the medical staff • must have licensed dietitian full-time or on a consultation basis	• facilities must be adequately equipped and staffed by qualified personnel to meet the needs and assure the safety of persons attending the facility and conform to all applicable statutory requirements for the provision of health care	New Haven Medical Hotel provides: • onsite Medical Director • 24-hour nursing staff through an onsite home health care agency • Emergency Medical Technician/ Concierge on each floor • certified recreation therapist • staff dietician
LINKAGE AND REFERRAL AGREEMENTS	• written transfer procedure to govern both scheduled and emergency transfers • emergency transfer procedures coordinated with the local Emergency Medical Services Authority • written agreement for patient transport with a licensed ambulance service	• not required to execute a patient transfer agreement with other hospitals that requires acceptance of patients that need emergency care or acute care • required to have a written agreement with an appropriately licensed hospital for immediate transfer of patients when special services are needed but are unavailable at the facility	• not addressed by statute or regulation • at the Surgical Recovery Center, Inc., all physicians must have admitting privileges at local hospitals which facilitates patient transfers when necessary	• hospital and ASC are partners in development of the New Haven Medical Hotel

DIMENSIONS OF POSTSURGICAL RECOVERY AND SUBACUTE CARE CENTERS IN SELECTED STATES

KEY ISSUES	CALIFORNIA	TEXAS	ARIZONA	CONNECTICUT
ACCREDI-TATION	• available from the Accreditation Association for Ambulatory Health Care, Inc. (AAAHC)	• available from the AAAHC • facilities meeting the standards of the Joint Commission on Accreditation of Healthcare Organizations or the Association of Osteopathic Physicians or those facilitiea that are Medicare-certified are deemed to meet Texas licensure standards	• available from the AAAHC	• not specified
REIMBURSE-MENT/FINANCE	• State charges participants a reasonable fee to cover actual cost of administering the program • demonstration program applicants must submit a $1,500 application fee to offset the State'a costs for reviewing responses to the program'a Request for Proposals. Fee is applied to the first year'a annual fee for successful applicants • facilities are not eligible for reimbursement from government programs (Medicare, Medicaid) because they are not licensed under the demonstration program • between September 1988 and June 1991, patient care was paid for by the following sources (all facilities): • 52 percent private insurance • 23 percent HMO/PPO arrangements • 10 percent self-pay • 8 percent worker's compensation • 6 percent Blue Cross/Blue Shield • 1 percent uncompensated	• not specified	• Arizona's medical assistance program has provided some reimbursement to the Surgical Recovery Center, Inc.	• some insurance carriers cover medical hotel expenses directly • At New Haven Medical Hotel • Blue Cross/Blue Shield was negotiating to provide reimbursement for medical hotel services prior to facility opening in January 1991, but no agreement has been reached to date • lack of licensure appears to be a stumbling block for third-party reimbursement, so facility is currently attempting to become licensed • patients of the Temple Medical Center, Temple Women's Surgical Center, or the Hospital of Saint Raphael may have New Haven Medical Hotel expenses paid for by the facility where they receive medical care if their insurance companies do not provide medical hotel coverage • medical services provided to guest-patients through the adjoining Temple Medical Center are billed to insurance carriers as outpatient services • many current guest-patients are self-pay

DIMENSIONS OF POSTSURGICAL RECOVERY AND SUBACUTE CARE CENTERS IN SELECTED STATES

KEY ISSUES	CALIFORNIA	TEXAS	ARIZONA	CONNECTICUT

DATA COLLECTION AND EVALUATION	• an evaluation is due to the legislature no later than six months prior to the conclusion of the project, assessing
	  • patient safety
	  • the manner in which care is provided
	  • cost effectiveness
	  • the most appropriate facility setting for providing postsurgical recovery care
	  • the need for a new license category or an amendment to existing standards
	• facilities must maintain records of program activities, data on patients served, costs, charges and other administrative issues to support the evaluation
	• Sharp Post Surgical Recovery Center, San Diego, is participating in a national study of recovery care cost effectiveness being conducted by Lewin/ICF for the National Recovery Care Association
		• Houston facility is participating in a national study of recovery care cost effectiveness being conducted by Lewin/ICF for the National Recovery Care Association	• Surgical Recovery Center, Inc., is participating in a national study of recovery care cost effectiveness being conducted by Lewin/ICF for the National Recovery Care Association	• New Haven Medical Hotel is collecting data on cost savings from combined ambulatory surgical transfer cases versus hospital cases and hospital transfer cases versus hospital cases
				• New Haven Medical Hotel is participating in a national study of recovery care cost effectiveness being conducted by Lewin/ICF for the National Recovery Care Association

LIABILITY COVERAGE	• not addressed in statute or regulation	• not addressed in statute or regulation	• not addressed in statute or regulation	• not addressed

COST CONTAINMENT			• hospitals are finding they can increase ambulatory surgery by 30% by substituting recovery care arrangements for their own acute care beds according to the Surgical Recovery Center, Inc., of Phoenix	• data from the New Haven Medical Hotel indicate that, based on an average LOS of 2.5 days in the Medical Hotel,
				  • an average cost savings of $3,504 per case was realized by ambulatory surgical transfers (comparing costs for ASC plus Hotel stay to costs for a hospital stay for the same services had the ASC/Hotel combination alternative not been available)
				  • a per patient savings of from $1,140 to $1,358 was realized by hospital transfers to the facility (comparing costs for hospital plus Hotel stay to costs for a hospital stay for the same services had the Hospital/Hotel combination stay alternative not been available)

DIMENSIONS OF SUBACUTE/POSTSURGICAL RECOVERY CENTERS IN SELECTED STATES

KEY ISSUES	FLORIDA	COLORADO	RHODE ISLAND	
LICENSURE	• currently not licensed • legislation was introduced during the 1991 legislative session to authorize, license and regulate subacute recovery centers as demonstration projects, but it failed to pass	• licensed under Ambulatory Surgical Center (ASC) act • issues waivers to certain requirements of the ASC regulations subject to particular conditions	• currently not licensed • licensure proposed for freestanding recovery centers, regulations are in draft stage of development	
CERTIFICATE OF NEED	• not addressed	• not applicable	• required	

CRITERIA	As defined by proposed legislation,
	Subacute Recovery Center:
	• a medical establishment that offers services which provide room and board for a period beyond 24 hours
	  • for persons requiring general nursing care under a physician's supervision following surgery; or
	  • for persons needing treatment and nursing care under a physician's supervision for illness, injury, infirmity, or abnormality
	• designated demonstration project site thst is either freestanding or a distinct part of an existing hospital facility
		Ambulatory Surgical Center:
		• facility which operates exclusively for the purpose of providing surgical services to patients not requiring hospitalization, not including a facility:
		  • licensed as part of a hospital
		  • providing services and/or accommodations for patients who stay overnight
		  • used as an office of clinic for the private practice of physicians, podiatrists or dentists except under specific conditions
		• waivers apply to restrictions on overnight stay and limits on surgical procedures based on generally required LOS not exceeding 8 hours
			As defined by draft regulations,
			Freestanding Recovery Center:
			• an establishment equipped and operated exclusively for the purpose of providing recovery services
			  • for patients one year of age or older
			  • which in the opinion of the physicisn
			  • can be provided safely
			  • require a stay of not more than 24 hours (may be extended to a maximum of 48 hours when the necessity of the extension is documented by the admitting physician and approved by the Medical Director)	

SCOPE OF SERVICE	• postsurgical recovery care
	• subacute care
	• ancillary services unspecified
		• surgical services
		• postsurgical recovery care
		• ancillary services
		  • laboratory (onsite or by contract)
		  • radiology (onsite or by contract)
		  • pharmacy (optional)
			• postsurgical recovery care
			• ancillary services
			  • pharmaceutical (onsite or by contrsct)
			  • lsboratory (optional)
			  • radiology (optional)	

DIMENSIONS OF SUBACUTE/POSTSURGICAL RECOVERY CENTERS IN SELECTED STATES

KEY ISSUES	FLORIDA	COLORADO	RHODE ISLAND	
LIMITATIONS	• minimum length of stay (LOS) of more than 24 hours; no maximum • no more than 50 total beds may be located in any Florida county having subacute recovery facilities • standards and operating regulations of the Florida Subacute Care Association, Inc., were be used as a model for rules under the proposed legislation	• waivers granted to two ASCs to allow them to admit up to two patients at any one time for up to 48 hours postsurgical stay • ASC policies and procedures affected by an extended stay (e.g., admission criteria, staffing, dietary, emergency, etc.) must be approved by the State	• 24 hours LOS planned, but limited to not more than 48 hours • accepts only preplanned admissions of persons one year of age or older who need recovery center level care performed and (1) who will need to stay at least overnight, but not more than 48 hours at the facility; and (2) whose condition would require them to be cared for on an inpatient basis if Recovery Care Facilities did not exist	
QUALITY OF CARE	• no formal quality assurance (QA) program is independently specified within the proposed legislation • standards and operating regulations of the Florida Subacute Association, Inc., referenced in the proposed legislation, have been requested but not yet received	• governing body is responsible for conducting, with provider staff, an ongoing comprehensive self-assessment of the quality of care provided, including • the medical necessity of procedures performed • the appropriateness of care • the appropriateness of utilization • Quality Assurance Program is required to ensure the adequate investigation, control and prevention of infections	• no formal QA program required by draft regulations • governing body must adopt by-laws including a statement of its method for assuring responsibility for the quality of care and services	

DIMENSIONS OF SUBACUTE/POSTSURGICAL RECOVERY CENTERS IN SELECTED STATES

KEY ISSUES	FLORIDA	COLORADO	RHODE ISLAND	
STAFFING	• not specifically addressed in proposed legislation	• organized provider staff • Director of Nursing, a professional registered nurse • at least one registered nurse must be in the facility at all times when a patient is present	• medical staff is composed of a Medical Director (physician) and all physicians, dentists, and podiatrists appointed by the governing board • nursing care service must be under the direction of a full-time licensed registered nurse who has training and at least two years' experience in postsurgical recovery nursing • at least two licensed nurses must be on duty at all times patients are present, one of whom must be a registered nurse certified for advanced cardiopulmonary life support • must have consultant pharmacist and consultant dietitian • must maintain current list of available medical consultants in specialty fields	
LINKAGE AND REFERRAL AGREEMENTS	• not specifically addressed in proposed legislation	• written transfer agreement with an emergency center/hospital, or all physicians performing surgery in the ASC must have admitting privileges at the hospital	• written transfer procedure to govern both scheduled and emergency transfers • emergency transfer procedures coordinated with local emergency medical services • written agreement for patient transport with a licensed ambulance service	
ACCREDI-TATION	• not specifically addressed	• available from the Accreditation Association for Ambulatory Health Care, Inc. (AAAHC)	• available from the AAAHC	

DIMENSIONS OF SUBACUTE/POSTSURGICAL RECOVERY CENTERS IN SELECTED STATES

KEY ISSUES	FLORIDA	COLORADO	RHODE ISLAND
REIMBURSE-MENT/FINANCE	• proposed legislation authorizes the State to set application and licensure fees in "an amount that will defray the cost of the administration" of the demonstration project • a facility identification number is to be issued to each participant in the demonstration project to facilitate reimbursement by third-party payors for medical services rendered	• not addressed by regulations, but data collected under waiver conditions	• not addressed by draft regulations

DATA COLLECTION AND EVALUATION	• as a condition for licensure, demonstration project sites must provide statistical data and patient information that the State deems necessary for effective evaluation
	• an evaluation is due to the legislature six months prior to the conclusion of the demonstration project, assessing
	  • the effectiveness and safety of the demonstration projects in providing recovery services to patients
	  • the need for a new license category or amendment of existing licensing standards
		• under the waiver, ASC must submit semiannual reports to the State that include a description and analysis of:
		  • number of total admissions and the number of admissions under the waiver
		  • average LOS for admissions under the waiver
		  • procedures performed under the waiver
		  • any variance in infections for procedures under the waiver
		  • complications and transfers from the facility to a hospital
		  • the forms and amount of reimbursement for admissions under the waiver
			• must report detailed financial and statistical data pertaining to operations, services, and facility, including
			  • utilization of recovery care services
			  • unit cost of services
			  • charges for services
			  • financial condition of the facility
			  • quality of care

LIABILITY COVERAGE	• not addressed in proposed legislation	• not addressed in regulations or waiver conditions	• not addressed in draft regulations
COST CONTAINMENT	• a March 1988 study[1] of subacute care offered in hospitals and nursing homes in Florida wss "not successful at gathering comparable subacute care cost and charge data"	• no data available at this time	• no dsta available st this time

APPENDIX G.

PUBLIC TESTIMONY: BIRTH CENTERS AND RECOVERY CARE CENTERS

TESTIMONY POINTS DISCUSSED ON APRIL 6, 1992 FOR ALTERNATIVE BIRTH CENTERS

ACCESS:

1. Pilot program being contemplated NOT focused on underserved areas. It would allow three in suburban Chicago, three in Chicago, three in other urban centers and three in rural communities. No guarantees of serving a real NEED.

2. Lack of facilities NOT the problem in Illinois as it is in many of the states that allow birth centers. Here a lack of qualified personnel is the critical need.

3. Birth centers in rural settings, operated on a free-standing basis will clearly jeopardize the existing community hospital obstetric programs. Who will be left then to take care of the complications?

4. In urban environments expanded outreach programs using multi-disciplinary teams based in community clinics, with births provided at hospitals offering a full range of birthing options, may be the most effective and safe model to address access problems.

QUALITY:

1. Again, to improve outcomes the focus should be on prenatal care and incentives for broader availability of qualified personnel--physicians and nurse midwives--not on new facilities.

2. Experience/data from other states VERY limited. With the exception of California and Texas very few free-standing programs in operation, with little data available for evaluation.

3. New England Journal of Medicine study flawed in that it failed to include a control group.

COST:

1. By adding additional facilities and fixed costs to a system which already has an abundant supply, authorizing free-standing birth centers will only raise overall costs.

2. The cost effective alternative is to make better use of the facilities we have by resolving the shortage of qualified physicians and certified nurse midwives.

John J. Barton, M.D.
Professor and Chairman
Department of Ob/Gyne
Illinois Masonic Medical Center

acog statement of policy

AS ISSUED BY THE EXECUTIVE BOARD OF ACOG

ALTERNATIVE BIRTH CENTERS

The hospital setting provides the safest atmosphere for mother, fetus, and infant during labor, delivery, and in the postpartum period. Birth centers, within the hospital complex and functioning under the protocols of the Department of Obstetrics and Gynecology, provide safeguards to ensure similar safety. Scientific methodology to investigate outcome of normal delivery adequately has been problematic as documented in a National Academy of Sciences study and until scientific studies are available to evaluate safety and outcome in free-standing alternative birth centers, such centers cannot be encouraged. There may be exceptional geographically isolated situations where special programs are necessary.

Approved by the Executive Board
December 3-4, 1982

THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS
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ASC
HEALTH SYSTEM

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April 20, 1992

Harold Duckler
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Chicago, Illinois 60601

Dear Mr. Duckler:

The purpose of this letter is to reduce to writing the substance of what I presented to the Hearing Committee with regard to the proposed statutory language which would allow for the first time in the State of Illinois the development of "free standing birthing centers". I have presented **in opposition** to this possibility, because I believe that free standing birthing centers, particularly those enterprises developed by entrepreneurs, would ultimately cripple hospitals with existing obstetric units, and would increase the shortage of obstetricians in rural areas.

As I indicated at the Hearing, I am the Administrator of St. Vincent Memorial Hospital, located in Christian County, south of Springfield. In my previous position as Vice President of Chelsea Community Hospital in Chelsea, Michigan, and in my current position, physician recruitment has been an extremely important part of my job. I have been at St. Vincent's for a little over 15 months now. For the last year and a half, the Hospital has attempted to recruit an OB/Gyn to its service area in Christian County. We have as yet not been successful, but we continue to exert our best efforts toward this goal, as the availability of an Obstetrician is seen by my Board of Trustees and our community as the "gold standard" for obstetrical care, even when Registered Nurse Midwives are utilized.

St. Vincent Memorial Hospital belongs to the ASC Health System. The ASC Health System is made up of four facilities serving south-central and southern Illinois. My sister facilities are St. Clement Hospital in Red Bud, Illinois, St. Joseph Hospital in Murphysboro, Illinois, and MariaCare Nursing Home in Red Bud, Illinois. Each of our hospitals have been providing service in our areas for many decades now. St. Vincent was founded in 1906 by our Sponsoring Congregation of religious women, the Adorers of the Blood of Christ, based

in Ruma, Illinois. As was the original intent by the Adorers, and as is the operating principle for us today, our facilities and our tradition has pointed us in the direction of service and providing for unmet needs. This can be an almost formidable task at times, especially these days when our Public Aid system is six months behind in paying facilities such as ours, (and in fact, is rated one of the most derelict of the 50 states in terms of payment time to providers). Just from St. Vincent's perspective, the State is in arrears well over one million dollars for services rendered to Medicaid recipients in our area.

Returning to the recruitment issue, the St. Vincent Memorial Hospital Board of Trustees has elected to continue active recruitment for an OB/Gyn, as opposed to recruiting a family practitioner or family practitioners who happen to also deliver babies. We believe that we need obstetrical medical skills available in our community for the inevitable significantly high proportion of cases in which complications arise in labor and delivery. At the same time, the ASC Health System and St. Vincent Memorial Hospital are very interested in developing an expanded obstetrical service through the wise use of Registered Nurse Midwives to increase our capabilities in our rural areas. In fact, St. Joseph Hospital in Murphysboro has recently recruited an OB/Gyn, and has two new midwives to start this summer to help bolster it's obstetric service.

The point I would like to make is that we believe that there is an appropriate role for midwives in any sort of alternative birthing scheme that may be developed. However, if an investor-owned free standing birthing center were to be placed near St. Vincent's or either of my sister facilities, hospital obstetrical units (already struggling under our current Public Aid situation) might have a number of the commercially-insured mothers pulled away, leaving the hospitals with a greater proportion of under-insured and uninsured mothers to serve. I feel quite certain that if a for-profit birthing center were placed in Taylorville, that it could well be the "straw" that would break the financial backs of both the one OB/Gyn presently on our staff, as well as the Hospital. If enough business were siphoned away, it could well drive our OB/Gyn away to another area (perhaps in a more populated, suburban area of the State) and would force St. Vincent's to reevaluate the continuation of its obstetrical services. I suspect strongly that St. Vincent's situation is very similar to many other hospitals in this area. It is ironic to think that a system intended to increase obstetrical care in our state could in fact end up "drying up" a number of practices of OB/Gyns who in fact do practice in rural Illinois at this time.

However, if birthing centers were to become a reality in Illinois, and if the birthing centers were required to be sponsored by local

hospitals or to work in conjunction with existing hospitals and their obstetrical services; or in the alternative, if birthing centers were compelled to provide their fair share of services to the indigent and to Public Aid recipients, this would certainly go a long way to provide better service to our citizens. I fear however that the provision of obstetrical services to the poor and needy is antithetical to the purposes to the entrepreneurial free standing birthing center philosophy. After all, such a free standing unit would have shareholders to report to, and maximization of profits would be the central orientation of such an organization. The strategy, it seems to me, would be for investors and management in such an organization to "skim the cream" of the best paying customers, and leave the "financial losers" to the established hospitals - - which may or may not have the financial wherewithal to survive the effects of a competitive birthing center which discriminates in service delivery on the basis of ability to pay. Ironically, the hospitals would be looked upon by the free standing birthing centers as the place needed to transfer patients who have complications and can deliver the higher degree of care not otherwise available at the birthing center.

It should be noted that hospitals are, and have been, developing various alternative birthing arrangements. For example, at St. Joseph Hospital in Murphysboro, and in the planning stages at St. Vincent's, we are developing Labor, Delivery and Recovery rooms, which will allow the delivering mothers to remain in a single, comfortable and dignified setting throughout these various stages in the birthing process. And as stated earlier, we are actively pursuing the midwifery option. However, we must keep a high level of technological capability and a 24-hour service in order to maintain the high standards required of us under licensure and accreditation guidelines. We are philosophically opposed to "cherry-picking" only the paying customers and the commercially insured. In fact, in a very real way, we are dependent upon the commercially insured to help us offset the losses that we incur in providing service to Medicaid patients, and the uninsured. The same is true for the obstetrician who is on the medical staff at St. Vincent Memorial Hospital.

For the foregoing reasons, I would recommend that our **opposition** to the proposed legislation on the development of birthing centers be endorsed by the Department of Public Health. Short of this, should the legislators decide that it would be prudent to move forward with pilot projects, I would vigorously promote that free standing birthing centers be developed in conjunction with area hospitals with acute care obstetrical services, and that if entrepreneurs are allowed to develop said free standing birthing centers, that they be required to carry their share of our societal burden. After all, if the investors are allowed the privilege of gaining an Illinois license to operate a birthing center within our state, then they ought also be required, as a part of their licensure, to

provide care to that proportionate share of the citizenry most in need of their services. Further, free-standing centers, should they become a reality in Illinois, must be required to operate under the same Certificate of Need, licensure/review, and other regulatory requirements that hospitals are subject to, so that a "level playing field" can be maintained.

Without these safeguards, the future of hospital obstetrical programs and hospital-based obstetricians, particularly in rural settings, are very much in jeopardy. Public Aid in Illinois now pays hospitals far less than their actual costs for services rendered to patients in this program. Hospitals literally loose money on each patient cared for under current payment mechanisms. The State is humbly implored not to inact this birthing center measure, at risk of crippling beyond repair the hospitals' ability to provide quality healthcare to the populations that we serve.

Thank you for the opportunity to present my concerns in this matter.

Sincerely,

Mark A. Cwiek

Mark A. Cwiek
Administrator
Opposition Spokesperson, Freestanding Birth Center Proposal

cc: Chris Bailey, IHA

To: MEMBERS OF THE ACUTE CARE TASK FORCE

From: Gina Novick
Chair, Birth Center Task Force
Health & Medicine Policy Research Group

Date: April 6, 1992

Re: TESTIMONY SUPPORTING BIRTH CENTER DEMONSTRATION PROJECTS

INTRODUCTION

I'd like to start off by offering an observation about this process as it's developed so far. I think we have moved away from the fundamental questions we need to be asking. Freestanding birth centers have been available for over 16 years in the US and abroad, and are an integral part of the health care system in 27 other states. Safety has been documented.

I would suggest that as we discuss these issues, the questions we need to keep in mind are:

1. Is there a reason that an alternative that women want should be illegal, even though it is safe, reduces cost and increases access?

2. Do we want to be prohibiting women from having this choice in Illinois?

Before I came to Illinois, I worked in 2 birth centers, participated in setting up a third, and was on the board of directors of a 4th. But let me also say, that the bulk of my background has been in hospitals. I am a Certified Nurse-Midwife, I worked at Cook County Hospital for 4 years, and have been working at the University of Illinois for the past year and a half. Before that, I'd worked in an urban, in-hospital birth center, a community hospital, and academic medical centers.

Among all these settings, birth centers have stood out as the most meticulous, compassionate, safe care I've ever seen.

DESCRIPTION

As you know, freestanding birth centers are ambulatory care facilities which provide antepartum, intrapartum, postpartum and immediate neonatal care to healthy women in a homelike atmosphere.

Birth centers differ from hospitals in primarily 2 ways: intervention is minimized, and care is intimate and personalized. First, I'd like to talk about intervention.

Birth centers care for low risk women, so routine intervention is inappropriate. Birth centers have no routine IVs, monitors, preps, enemas, episiotomies, or medications. What patients can do in birth centers that they often cannot do in hospitals is walk, eat, sit in the family room, deliver in or out of bed, develop a personalized birth plan, and assume different positions throughout labor and birth.

By minimizing unnecessary intervention and offering nontechnological methods of pain relief and stimulating labor, iatrogenic complications are reduced. When iatrogentic complications are reduced, the rate of cesarean section decreases.

The homelike design of birth centers is intended to function around the needs of the patients in a way that larger institutions simply cannot do --including LDRPs (labor-delivery-recovery-postpartum rooms) and in-hospital "birth centers". This is accomplished in sever ways.

1) First of all, birth centers are decentralized facilities, so that a pregnant woman can receive comprehensive care right in her own community.

2) They provide culturally-sensitive care - a Hispanic woman going to a birth center in her own neighborhood can receive care from people who speak her language, understand her culture, and perhaps some of the traditions that may affect her health behaviors.

3) It's unfortunate that The Acute Care Task Force can't make a site visit, because you get a very different feeling when you walk into a birth center. They are small, intimate facilities, with kitchens, family rooms, play areas, lending libraries--all designed to help people feel at home and in control. Waiting times are short.

4) During the course of prenatal care, families become acquainted with the birth center and the care providers so that when they come in in labor, it is not a strange environment.

5) In addition, there are generally no restrictions on the number or type of support people who can be at births, including siblings. The newborn baby remains continuously with the mother after birth; this promotes breastfeeding and bonding.

Early discharge enables families to continue to be together after birth. And, unlike many hospital discharge programs, there is close postpartum follow-up, including home visits, and/or more frequent return visits to the center and/or telephone contact by the birth center with postpartum families.

6. Patient education is the linchpin of birth center care. There are prenatal classes - not just Lamaze-type preparation for birth, but early prenatal classes - nutrition, exercise, and after delivery, parenting, teen groups and many others, depending on the needs of the community. In some communities, birth centers have become commmunity centers, with a variety of educational programs, selected and arranged by the participants.

Patients are encouraged to become autonomous: they are taught to weigh themselves, test their own urine, and chart the results themselves.

Through these programs, and through a provider-intensive approach to prenatal care that considers continuity of care, patient education and patient autonomy critical components of care --not luxuries --patients become partners in their care. It is no accident that the average number of prenatal visits in birth centers is 11.3.

The philosophy underlying the approach to care in birth centers is: if patients become comfortable with their care, health behavior can change, thereby reducing complications and improving outcome.

SAFETY

Safety has been documented in numerous small studies, but most recently, in a prospective study of over 11,000 women who gave birth in 84 birth centers, over half of the birth centers in the country. This study was published in The New England Journal of Medicine (321:1804-1811; December 28, 1989). Statistics that follow are from this study.

1) Rigorous screening assures that BC's provide safe care to low risk women.

There is an extensive orientation to birth centers and an elaborate informed consent process so that people understand the difference between what birth centers offer and what hospitals offer. Birth centers are not everyone's choice, and they want to assure that their clientele is informed and enthusiastic about this option.

A rigorous screening process detects medical or obstetrical complications which would render a woman ineligible for birth center care. This process continues throughout pregnancy, birth and the postpartum period. As a result, some people are ineligible for birth center care, and some patients transfer out of birth centers.

Transfer rates are as follows:

Antepartum- 14.3%
Intrapartum- 11.9% - most of these are before delivery
Postpartum and neonatal - 2.5%

It must be emphasized that transfer is not considered failure. It is the way the system is intended to work. Women receive care in the facility that is most appropriate for their level of risk, and if the risk status changes, the setting changes. This is screening and triage to the appropriate level of care.

Almost all transfers are non-emergency (primarily failure to progress and prolonged rupture of membranes). These transfers are leisurely and occur in a car or taxi, not an ambulance.

The emergency transfer rate is 2.4%, and the NEJM study reported no maternal deaths and a combined neonatal and intrapartum mortality rate of 1.3/1000, (0.7 if lethal anomalies are excluded) which is similar to that of large studies of low risk populations in hospital. Outcomes do differ between birth center and hospital populations in the following manner: the cesarean section rate of birth center patients is 4.4% - roughly half that of comparable hospital populations studied!

The vast majority of complications can be anticipated. However, in the rare event of an unanticipated IP emergency, staff consists of professionals educated to intervene rapidly and stabilize patients. BC's are equipped with oxygen, blood volume expanders, resuscitation equipment, and maternal and neonatal emergency drugs.

Birth centers always have linkage to existing backup systems including ambulance transport to a nearby hospital arranged by prior contractual agreement and an on-call physician with hospital privileges. Most birth centers are less than 10 minutes from their back-up hospital and 30% are less than 5 minutes away.

Consequently, in the event of an unpredictable emergency, a "decision-to-incision" time of under 30 minutes could be easily implemented.

For example, imagine the diagnosis of a prolapsed cord after spontaneous rupture of membranes. At the time of diagnosis, the care provider would perform the approprate maneuvers to decrease pressure of the fetal head on the cord, and instruct an assistant to initiate emergency transfer for cesarean section for a prolapsed cord. The assistant would then contact the ambulance for emergency transfer to the nearby back-up hospital, notify the on-call physician to meet the ambulance at the hospital, and notify the hospital to set up the operating roon for emergency cesarean. The patient could easily be in the operating room within 15-20 minutes, often less. In comparison to the community hospital that I worked in which did not have an obstetrician, a pediatrician or an anesthesiologist in the house at all times, this timing would be an improvement.

WHO IS SERVED BY BIRTH CENTERS?

Approximately 70% of birth center clients are middle-class, and upper middle-class, well-educated women. In recent years, however, several birth centers have been established for the medically indigent. In particular, I'd like to draw your attention to the birth center which was established 3 1/2 years ago in an impoverished, violent area of the south Bronx. Over 400 births have occurred there, and statistics in the Bronx are comparable to statistics of birth centers nationwide.

This surprises many people, because there is a widespread perception that low income and uneducated women are automatically high risk. However, because of careful screening and triage to the appropriate level of care, accessibility, shorter waiting times and friendly, culturally sensistive care, we feel that this is an important option to have available to low income women.

We talk about access to care for this population a lot, but we must examine what access really means, and what the content of that care is. I'd like to talk for a minute about my experience at Cook County Hospital. There were women at County who traveled 2 hours on public transportation, often with several children, only to wait for hours in a crowded, unairconditioned waiting room with a hundred other women and no facilities for children. They would wait for hours--sometimes 4, 5 or 6 hours to see a provider whom they'd never seen before, and might never see again, and who might not even speak their language.

These women would leave visits with a prescription and a return appointment and orders for a bunch of tests that they didn't understand, and perhaps none of their questions or concerns addresssed. Is a woman who's had that experience going to follow through on her tests, or take her prescriptions? Is she going to show up for any more care, or for a referral to a perinatologist or high risk clinic if she hasn't a clue why she should?

Even when people live across the street from a hospital, does it matter if they won't come back for prenatal care because in so many instances their experiences are impersonal and fearful -- perhaps because hospitals are designed to care for the sick and dying?

How are we going to have an impact on infant mortality in this state? More and more technology is not the answer in itself, while technology of course, has its use. It is by reducing low birth weight, which must be done by decreasing the incidence of premature birth and preterm labor. We all know that one of the primary ways to accomplish this is through consistent prenatal care and by changing the way people take care of themselves.

Here we have a way that we can do that. Women respond to humane, sensitive care - with trust, by opening up, asking questions, learning what they need to know in order to take care of themselves. And if they begin to take responsibility for themselves, they will start taking responsibility for the health and welfare of their families and communities as well.

Thank you very much for the opportunity to share with you my personal experience and professional judgement regarding the clear merits and value of birth centers and to ask that for those who harbor doubts and fears about the impact of the birth center model, to at least allow closely monitored demonstration projects to be established in order to test the validity of those concerns.

ILLINOIS PRIMARY HEALTH CARE ASSOCIATION

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TO: MEMBERS OF THE ACUTE CARE TASK FORCE

FROM: Lon Berkeley
Executive Director
Illinois Primary Health Care Association

DATE: April 6, 1992

RE: **RATIONALE FOR BIRTH CENTER DEMONSTRATION PROJECTS**

Summary of April 6, 1992 Presentation to the Acute Care Task Force of the Illinois Department of Public Health:

A. **Background re IPHCA and Community/Migrant Health Ctrs** (see attached information sheet)

B. **Reasons for Community Health Center CHC) Interest in Birth Centers:**

1) Addresses severe financial access problem for both pre-natal and labor/delivery care

2) Positively impacts other access barriers, e.g. geographic, linguistic, temporal, cultural

3) Responds to federal encouragement of "one-stop shopping" programs to address infant mortality problem

4) Consistent with CHC orientation/philosophy of family, patient education, self-care, empowerment/control, choice

5) Increases ability to recruit and retain vitally needed physicians (OB/GYN, Family Practice) and certified nurse-midwives, esp. in rural areas

6) Quality of care and safety demonstrated

7) Helps improve continuity of care with required system linkages to hospital, ambulance, and home care services

8) Cost-effectiveness and reduction in Medicaid and other third-party expenses (see previously distributed cost savings-related documentation)

C. **Range of Settings Possible:**

* Hospital premises/campus ("level 0")
* Community Health Center affiliated
* Post-Surgical and Obstetrical Center (PSOC)
* "Mega-Clinic" complex
* Doctor's Office related
* Local Health Department
* Free-standing

D. **Response to Concerns Raised Re Birth Centers:**

1) Position of Am Coll of Ob/Gyn (ACOG)

RESPONSE:

- out-dated (1983) statement; no update since add'l studies available
- still notes acceptability in remote area situations and within hospital complex
- currently receives active support from national medical leaders: ACOG Past President (Dr. J. Robert Willson); President of NY Acad of Medicine (Dr. Bernard Pisani, OB/GYN); Fla. Commissioner of Hlth (DR. Charlie Mahan, OB/GYN)
- recent testimony by ACOG District II - NY State: "We believe that the standards of safety require that delivery is best performed in a hospital or licensed birthing center."
- ISMS support of PSOCs for past two yrs
- HMPRG petition of over 50 IL physicians supporting birth centers
- nat'l accreditation standards and process for Birth Centers now available

2) Hospitals Fear of "Skimming" Paying Patients

RESPONSE:

- Feedback from other state Hosp Assns w/ Birth Centers indicates no such impact
- More likely that low income/indigent patients would use than paying patients due to significantly lower costs
- Potential to attract patients currently leaving the area for care or planning home births
- Applicants must receive CON which considers economic impact on surrounding facilities

COMMUNITY HEALTH CENTERS IN ILLINOIS

Located in the cities, small towns and rural communities of Illinois, Community Health Centers are diligently working to provide quality and comprehensive health care services to the poor and medically indigent. While these facilities vary according to the needs of the communities that they serve, all Community Health Centers are not-for-profit, governed by community-based boards, and organized to provide coordinated health care services to persons with limited incomes, Public Aid recipients, unemployed persons, migrant populations, and those living in health manpower shortage areas. Community Health Centers provide services at over 60 locations to more than 250,000 persons in Illinois every year.

Why are Community Health Centers Important?

In many rural areas, there simply are no physicians, and Community Health Centers provide the only source of medical care. In some small towns, medical services are not available for those who can't afford insurance and some physicians will not see Medicaid patients because of the cumbersome reimbursement process and low rates. Community Health Centers offer quality and comprehensive health care services to all that need it. In Illinois' cities, the Community Health Center is often the centerpiece of a neighborhood, offering a broad range of medical services and health enhancing activities directed toward the poorest and most vulnerable segments of society.

Community Health Centers employ board certified physicians and offer specialized prenatal and obstetric, pediatric, adolescent, adult and geriatric medical services. They also provide social services, nutrition counseling, health education, and teen pregnancy prevention programs. One of the most effective programs utilized by all of the Community Health Centers is a sophisticated case management and case finding system that seeks to prevent vulnerable patients from "falling through the cracks." The Community Health Centers have linkages for assuring inpatient care, emergency services, home health services and long term care. Some Centers are involved with special initiatives such as the provision of health care services to the homeless, offenders in the prison system, coal miners with respiratory problems, and high risk pregnant women and their babies.

Community Health Centers, when necessary, have expanded their service capabilities depending upon the needs of the communities that they serve. For example, a Community Health Center in the far southern part of the state recently increased its services to include emergency care when the local hospital was forced to close leaving the community without access to emergency services.

What Makes a Community Health Center Different?

While each Community Health Center is unique, both in history and in structure, most have the following features:

* the direct provision of comprehensive primary care and ancillary services through a multi-disciplinary team approach;

* an orientation that emphasizes prevention, patient education, family focus and cultural sensitivity;

* specialty, inpatient hospital, long-term care and rehabilitative services provided in a coordinated manner through affiliations to insure continuity of care;

* governance by community boards and participation in community activities and organizations;

* special programs designed to address the unique needs of their communities;

* sliding scale or low fees and located near public transportation, if available;

* quality assurance standards and systems.

As an average, the Community Health Centers have a patient mix that is approximately 66% Medicaid reimbursed, 30% uncompensated and sliding scale and 4% private insurance. Fifteen of the organizations receive federal grants under the Public Health Service Act. All the Community Health Centers depend on private contributions and public and private grants to subsidize the care that they provide for Medicaid and indigent patients. It is indicative of their value to their communities that these Centers have managed to survive despite decreased federal funding and long delays in Medicaid payments.

The **Illinois Primary Health Care Association** represents the Community Health Centers in Illinois. The Association can be contacted by writing or calling:

STEPHEN E. CARLSON
RECRUITMENT SPECIALIST
ILLINOIS PRIMARY HEALTH CARE ASSOCIATION
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TESTIMONY BEFORE THE ACUTE CARE TASK FORCE

Presented at April 6, 1992
State Capitol Building
Springfield, Illinois

Robert M. Klint, M.D.
President and Chief Executive Officer
SwedishAmerican Hospital
Rockford, Illinois

Good Afternoon. My name is Dr. Robert Klint, and I am president of SwedishAmerican Hospital in Rockford. I appreciate the opportunity to speak with you today about alternative health care delivery settings.

First I'd like to briefly acquaint you with my hospital for it provides some of the background for my subsequent comments. SwedishAmerican, like so many other hospitals is successfully making the transition from a system relying predominantly upon patients in beds to one in which outpatient care and short stay programs are a significant part of our programming and income. We will care for more than 44,000 people in the emergency department and count more than 150,000 out patient visits. We have the largest surgical program in Illinois' second largest city and 60% of those procedures are performed on an outpatient basis. Approximately twenty percent of our activities are provided to Medicaid patients and the number is growing. We have a special program for Short Stay Patients, those who are in the hospital less than twenty four hours. I believe we have a working understanding of how surgical care to inpatients and outpatients is and can be provided with quality and Equality.

I am here to offer testimony and evidence which we believe make a clear and convincing case for rejecting the free-standing birthing and recovery delivery models that have been proposed. The circumstances in Illinois and the experience gathered from other states lead us to conclude that the Alternative Health Care Settings Act will fail to address an access problem; will duplicate existing resources; will raise costs; will discriminate against some patients; and will fragment the delivery system further.

My remarks will focus on free-standing recovery centers. I will specifically address the five criteria outlined in Section 20 of the draft.

Criteria 1-- The feasibility of operating the model in Illinois based on a review of the experience in other states including the impact on health manpower and fiscal viability of other health care programs or facilities.

Recovery centers differ from surgicenters in several important ways. One provision allows the recovery centers to keep selected patients in beds over night or longer when there are complications of the surgery or the anesthesia. Actual experience with this model is quite limited. Only California has any broad experience to refer to. To be financially successful, these recovery centers require a large, commercially-insured patient population from which to draw the less acutely ill. They also require proximity to a full-service hospital, one that participates in the trauma system to handle emergency referrals. All of these factors make location of these centers feasible only in high density urban markets currently well served by hospitals in Illinois. They have not proven to be feasible in either underserved rural or urban settings.

→ many hospitals not in growing areas like Stuard.

There is no evidence that recovery centers have served to attract additional health manpower to an underserved community. Experience has also proven that free-standing recovery centers do pull away from existing providers the low acuity commercially insured, thus jeopardizing the financing base for hospitals, and further exacerbating some of the very problems that give rise to such proposals in the first place. All four California centers receive <u>private</u> insurance funds, but because the federal government has not approved them for overnight stays, they cannot receive either Medicare or Medicaid reimbursement. Such facilities would therefore not be feasible in areas with large numbers of such patients.

I believe a so called recovery center in our market would seriously threaten the financial viability of our outpatient surgery program and our ability to continue providing such services to ALL patients regardless of their ability to pay or source of healthcare coverage. That view is shared by all five acute care hospitals in our primary market and the vast majority of its physicians.

<u>Criteria 2</u>--The potential of the model to meet an unmet need.

In Illinois, we have facilities qualified and licensed to treat people for three days or longer (or shorter) following an elective surgery procedure--they are called hospitals. They have emergency services and treat all members of the community--Medicare, Medicaid, and the uninsured included. In fact, nearly one-half of the patients treated in Illinois hospitals have lengths-of-stay of three days or less currently.

What is being proposed is a hospital without an emergency room door open to all members of a community. A facility that will not be reimbursed by or accessible to Medicare/Medicaid recipients. Is there really an unmet need in Illinois for what are essentially additional hospital beds? Clearly the answer is no, given the fact that 24 hospitals have closed in the last five years, and more than 10,000 beds have either been eliminated or converted to other uses.

In theory, recovery centers could serve as a substitute for hospitals in rural or underserved communities. However, because free-standing recovery centers need a hospital close by for situations for which they are not equipped to handle, and because recovery centers are entirely dependent on commercial insurers, they can not flourish in medically underserved areas. Perhaps more importantly, recovery centers lack the service most in need in underserved communities--emergency medical care. California's experience proves that recovery centers locate in urban communities already well-equipped with full-service hospitals. For these reasons, the Prospective Payment Assessment Commission (ProPAC) in their June 1990 report on recovery centers expressed significant concern that recovery centers would duplicate service already available and questioned the wisdom of adding capacity for medical/surgical care.

It seems quite unlikely that there is tangible unmet need for these services in DuPage, Kane and McHenry counties as the draft bill suggests. There is no unmet need for these facilities in Rockford, one of the potential sites suggested in section 30. Those needs are being met by hospitals right now. I am concerned that if there are successful centers in more affluent counties and unsuccessful or non existent centers in urban cities, as the California experience suggests, the program will appear to discrimante against those receiving Medicaid assistance.

The evidence seems abundantly clear, in Illinois recovery centers will just duplicate existing services and will not meet an unmet need.

Criteria 3--The potential of the model to reduce health care costs to consumers, third party payors and aggregate costs to the public.

Proponents of recovery centers argue that they offer a lower cost alternative to hospital care. This argument is a fallacy based on invalid comparisons and a short-term view of the economic consequences associated with the establishment of free-standing facilities such as recovery centers. Of course the average charge of a less acutely ill patient treated in a facility like an ambulatory surgical treatment center will be lower than the average charged to patients treated in a hospital. The hospital treats, on average, more severely ill patients and it has all the facilities, equipment and staff to treat emergency cases. What happens if a recovery center locates near a hospital? Well, the private pay low acuity elective surgery patients are pulled away and the hospital simply must spread its cost for essential services--services such as an emergency room and intensive care unit that the community cannot afford to be without--over fewer patients. The result, higher charges for those inpatients who would remain in the hospital and higher costs of maintaining the Medicaid program.

To maintain operations and programs hospitals raise prices even further to those who require hospital care. Cost shifting, raising charges to compensate for those who cannot pay, is already an astronomical problem. The Rockford Council for Affordable Healthcare has researched this problem in our community. In 1990 there was more than $60,000,000 of shifted costs in Rockford alone. Allowing more surgical beds through the Recovery Center experiment will only make our problems greater. More minihospitals are not the answer to the aggregate cost problem.

Criteria 4--The potential of the model to maintain or improve the standards of health care delivery in some measurable fashion.

The fundamental concern about the quality of care in these settings stems from the fact that patient screening currently cannot adequately predict whether high-risk and potentially life-threatening conditions will arise during the course of many procedures proposed to be treated in the recovery centers. People are not the same. Recovery centers are simply not equipped to deal with such situations when they do arise.

Hospitals now have in place a set of regulatory policies and requirements that govern the provision of medical care of sufficient acuity to require overnight stays. And the recovery centers proposed in this legislation seek to offer

the equivalent level of service without complying with the same rigorous medical staff credentialing, peer review and quality assessment and quality improvement programs.

I serve the Illinois Hospital Association as Chairman of the Blue Ribbon Board on Quality. We have discussed the variety of parameters usable for monitoring and improving quality. Access is an important one. Clinical outcomes are crucial ones. I believe the need to improve access for those now in search is not addressed by the creation of Recovery Centers and see nothing in the bill or the California experience to suggest the outcomes are bettered. At best we could only hope for parity with what the hospitals are now providing.

Criteria 5--The potential of the model to provide increased choices or access for patients.

Recovery centers do not offer a service that is not available currently to the citizens of Illinois. They simply offer a different setting in which to make that service available. There is no clear distinction in the nature of care provided. And the costs to the community for offering an alternative setting choice are very substantial: costs of duplication, costs in wasting that community's investment in its hospital, and potential costs in quality. Real improvements in access to care involve making available a resource or a type of medical care previously unavailable to a community. Recovery centers fail to address that need.

We are in the midst of a profound and fairly lengthy debate in this country about the fundamental nature of our health care delivery system. Disagreements abound and common ground appears limited. But let me conclude by offering one notion for which there does appear to be agreement. All of us--consumers, providers, payors, policy makers, regulators--are searching for ways to make the health care non-system into a "system." Research demonstrates that both quality and cost effectiveness may be improved through better integrated delivery systems--systems which are geared towards improving the overall health status of the entire community. Systems which are responsible for managing the continuity of patient care across providers and over time, and delivery systems which eliminate the traps of conflicting financial and regulatory incentives that promote waste and duplication.

A critical flaw of the free-standing recovery center model is that it moves in the opposite direction. It offers entities which will fragment care further, new facilities which will offer a very narrow set of services not accessible to the entire population, and which would duplicate existing resources.

We do have other choices for which I believe broad agreement can be found. I sincerely hope that the Task Force will extend its evaluation beyond the recovery and birthing center models and focus instead on real solutions to access limitations and the needs of Illinoisians. I won't belabor them, but just to offer a few points that could be the basis of more extensive testimony at a future hearing I hope you will consider promotion of the following:

- Organized ambulatory care centers such as federally qualified health clinics which could promote access to effective primary care--and avoid relying on hospital emergency rooms.

- Financial and regulatory incentives for emergency system networks such as those in the federal EACH program.

- Targeting state resources towards promoting the supply and use of mid-level practitioners for facilities offering critical services in underserved areas.

As you evaluate each of the components of the Alternative HealthCare Settings Act, we ask that you apply two questions, "Alternative to what? and Alternative for whom?" Thank you.

AUSMS
FROM IDEAS TO RESULTS

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April 8, 1992

Patti Cox, Office of Health Statistics, Policy and Planning
Illinois Department of Public Health
535 West Jefferson Street, Room 500
Springfield, IL 62761

RE: 4-6-92 Testimony to the Acute Care Task Force

Patti
Dear Ms. Cox:

As per your request earlier today, enclosed please find a written version of the testimony presented by Pamela J. Wayne, Carolyn A. Caine and myself at Monday's hearings before the Acute Care Task Force.

In response to the interest you expressed in correlating our testimony with the criteria appearing in Section 20 of the Alternative Health Care Settings Act, I have cited specific criteria at the conclusion of each statement in which we believe they have been addressed. I would like to note that the entirety of our testimony, including our written submission, addresses Criteria #1.

Since we were not able to engage in a discussion with the Task Force following our presentations, we would welcome any questions which Task Force members may have, if you would like to forward them to me. Please note that Ms. Wayne is preparing a response to Dr. Goyal's question regarding revenue sources and will forward this to you next week.

We would also appreciate receiving a copy of all of the testimony which is submitted to you in writing, including the testimony of the PRC opponents, for our records, if this is acceptable to Ms. Pollard.

I shall look forward to hearing from you regarding any questions you or the Department might have about our oral and written testimony.

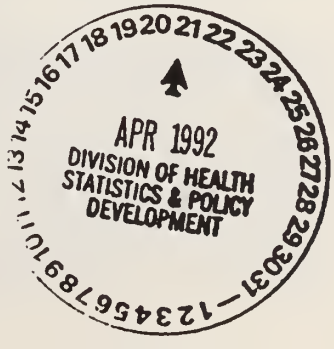
Thank you.

Sincerely,

Joni M. Steinman

Joni M. Steinman, Senior Vice President

Enclosure



TESTIMONY

in support of a
Postsurgical Recovery Center Demonstration Program
in the State of Illinois

Presented to:

Illinois Department of Public Health
Acute Care Task Force
Springfield, Illinois

Presented by:

Joni M. Steinman, Senior Vice President
AUSMS Incorporated Healthcare Consultants
San Diego, California

Pamela J. Wayne, Administrator
Sharp Post Surgical Recovery Center
San Diego, California

Carolyn A. Caine, President
Surgical Recovery Center, Inc.
Phoenix, Arizona

April 6, 1992

TESTIMONY OF JONI M. STEINMAN

Ms. Pollard and Members of the Task Force:

Thank you for inviting us to offer our comments to you in support of a postsurgical recovery center demonstration program.

My name is Joni Steinman. I am co-founder and senior vice president of AUSMS Incorporated Healthcare Consultants. AUSMS has been advising the health care industry, including governmental agencies, for the past 10 years on strategic, organizational and facility planning matters. We have a national practice and have been refining postsurgical recovery center models of care since 1988.

It is our understanding that the issue at hand is whether or not to test PRCs as an alternative health care setting, rather than whether PRCs are per se a good or bad service concept to introduce into the Illinois health care delivery system. In order to augment our oral testimony to you today, we have provided the Task Force with written materials.

Myths abound about PRCs. These myths include:

- o PRCs do not choose to serve Medicare/Medicaid patients;
- o PRCs are a supplement to hospital care;
- o PRCs provide subacute care;
- o PRCs are not feasible in rural areas;
- o PRCs are merely unregulated mini-hospitals;
- o PRCs are not receiving third-party reimbursement; and
- o PRCs provide a substandard quality of care.

I hope that the least that we can do for the Task Force today is to dispel some of these myths.

But, the most virulent myth making its way around the country is that hospitals oppose PRCs and are not themselves proponents of PRC development. Nothing could be further from the truth. Let me cite several examples which establish doubt regarding this mythical assertion.

First, AUSMS' client roster for PRC-related projects since 1988, when we were first engaged by Sharp HealthCare, San Diego's largest hospital system, to establish one of the first California PRCs, is comprised primarily of hospitals around the country who consider PRCs a way in which to:

- o offer alternative settings in which patients can obtain needed care (cf. #5);
- o augment ambulatory surgery programs with high quality, acute, inpatient support for those patients who would otherwise have to be hospitalized (cf. #4); and
- o respond effectively to the increasing presence of managed care payors (cf. #3).

Secondly, though the California Association of Hospitals and Health Systems vigorously opposed the enactment of SB 1953 which established the PRC demonstration project in 1986, over 60% of the applicants for designation as a demonstration site have been hospitals.

And lastly, last week I was approached by a senior editor of **Hospitals** magazine, a publication of the American Hospital Association, prior to my seminar on PRC planning at the AHA's Society for Ambulatory Care Professionals annual meeting (Note: The Society represents hospital administrators whose primary areas of responsibility include ambulatory care, outpatient surgery and emergency services). He looked around the room as the audience of about 125 hospital administrators was gathering to participate in the seminar and asked me "Don't hospitals oppose PRCs?" Since I recalled that he had attended our first PRC session at SACP's 1991 annual meeting, I suggested to him that the attendance at our 2 SACP sessions alone was probably indication enough that many hospitals were eager to introduce PRCs into their systems of care.

Though puzzled, he then asked, "Then why do hospital associations actively oppose PRCs?" Since I assumed that this was, in part, a rhetorical question, I did not attempt to conjecture an answer on behalf of my colleagues in hospital association management. Whenever we speak on the topic of PRCs, we are approached by hospital administrators who are present because they are charged with making PRCs a part of the implementation of their hospital's strategic plan for the future.

Illinois is joining other progressive states in encouraging a demonstration of the postsurgical recovery center concept. Our research indicates that at least 13 states have authorized postsurgical recovery centers, either permanently or on a demonstration basis, or are engaging in formal talks with state agencies to do so. In at least 14 other states, providers are exploring how postsurgical recovery centers can be introduced into their communities and states (cf. #1 for this paragraph).

The California demonstration project, which has attracted an exceptional amount of national attention, is well described in IDPH's summary. I shall only emphasize for the Task Force that the California demonstration is testing a wide variety of PRC models, though all must provide acute inpatient care to eligible patients following appropriate surgical procedures, whose prognosis for recovery is for more than a "business day" but less than 48 hours, with an option for the patient's physician to extend the stay for up to 24 additional hours. In other words, these patients would have to be admitted to the hospital for both their surgery and recovery were it not for the availability of a PRC in their community. I would also like to note for the Task force that California's hospitals are operating at about 60% overall occupancy; so it is a fatuous claim to assert that PRCs were started in California as an alternative to hospital overcrowding (cf. #1 for this paragraph).

It has been postulated that, of the 25 million surgical procedures being performed each year in the United States, an average of up to 20% of these procedures might be appropriate for recovery in a postsurgical recovery center, while 60% would be day procedures and the remaining 20% would require hospitalization (cf. #2).

PRCs therefore are a direct response to changing market, economic and political conditions affecting health care in certain parts of the country. In particular, PRCs provide an alternative for patients whose health history and status does not demand the array and intensity of resources normally available in a general acute hospital, resources which are usually not applied on the patient's behalf during their hospital stay (cf. #3). When considering the role which PRCs can play in the health care system, I like to use the analogies presented to us by other industries. For example, would it be apropos for the Illinois legislature to ban the operation of "convenience stores" because they are competitive with supermarkets and have forced them to stay open longer and open more check-out stands during rush hours? Or would it be wise to enact a law which proscribes banks from offering automatic teller machines to their customers, because they permit most people to perform the majority of their banking transactions without having to use a bank facility or personnel? To deny a PRC demonstration in Illinois would be tantamount to suppressing this type of creative response on the part of local health care providers, including hospitals, to their respective communities.

I also wanted to commend the Task Force and the Department on drafting a bill the language of which appears to go a long way to mitigating against certain of the defects inherent in other PRC programs which may compromise the validity or reliability of the test itself, including:

- lack of facility licensure;
- access limitations; and
- inability to obtain Medicare or Medicaid certification.

Your efforts to focus attention away from commonly-held notions which ascribe particular levels of care solely to particular settings of care is also laudable and may be an important step in negotiating with HCFA to establish "level of care" reimbursement formulas for acute inpatient care similar to those which HCFA now uses for hospice care (cf. #3).

A variety of providers are enthusiastically pursuing the development of postsurgical recovery centers including (cf. #1 and #5):

- Hospitals;
- Ambulatory surgery treatment centers;
- Medical groups;
- Long-term care providers; and,
- Entrepreneurial businesses.

In addition, postsurgical recovery centers are being tested in a variety of configurations, including (cf. #1):

- Stand-alone facilities;
- Extensions of ambulatory surgery treatment centers;
- Components of ambulatory care campuses;
- Wings of long-term care facilities;
- A floor of a hospital; and,
- A hospital.

In conclusion, matching patient needs more directly with the level of care and resource intensity they require and which our health care delivery system can offers to them is more important today than ever in the past (cf. #4 and #5). A test of the postsurgical recovery center concept of care in Illinois therefore appears both prudent and timely.

Thank you and I look forward to continuing to be a resource to the Task Force and the Department as you develop your state's PRC demonstration.

Response to question from Mr. O'Neill regarding the participation of rural sites in the California demonstration: A separate bill was enacted to establish that at least one of the thirteen demonstration sites be in a rural area. The first entity which was designated was for a project which my firm prepared for Washoe Health System of Reno, Nevada, for a PRC to be located in Susanville, California. Susanville is the county seat of Lassen County in the eastern Sierra Nevada mountain range. Susanville's 7,000 residents regularly seek health care in Reno as it is easier to get to, especially in the winter, than are other California cities on the western slope of the mountains. This 7-bed PRC was designed into a wing of a long-term care facility, which was one component of a health care campus being developed by Washoe which was to include an ambulatory surgery center, medical offices and a retirement community. Unfortunately, the statute which created the rural PRC provision required that the PRC be "freestanding" as opposed to a "distinct part" of an existing licensed inpatient facility, as was the case with the Washoe project. The Office of Statewide Health Planning and Development was not in a position to grant a waiver of this clause nor were we able to show a freestanding unit as economically viable. Thus, the designation was not acted on and another project was designated for a 20-bed freestanding PRC in San Luis Obispo, a community of 35,000 people, located mid-way between Monterey and Santa Barbara on the coast. This site is scheduled to open in October 1992 and is cooperative venture of the 3 local hospitals, both ambulatory surgery centers, physicians and the business community (cf. #2 for this paragraph).

TESTIMONY OF PAMELA J. WAYNE

My name is Pam Wayne. I am the administrator of the Sharp Post Surgical Recovery Center. I am trained as a Registered Nurse and hold a Master's in Health Administration degree from San Diego State University. I have been the administrator of the PSRC since before its opening in January 1990. The Sharp PSRC is an operating unit of Sharp HealthCare, San Diego's largest hospital and health care system.

Sharp HealthCare is both vertically- and horizontally-integrated and includes 5 general acute care hospitals, 4 of which are located in San Diego County and one of which is in southern Riverside County. In addition, Sharp owns and operates 2 skilled nursing facilities, an ambulatory surgical center (with physicians), 15 primary care clinics and 2 medical groups which represent over 300 physicians. Sharp employs approximately 10,000 employees. We are an active member of the American Hospital Association, the California Association of Hospitals and Health Systems and the San Diego-Imperial County Hospital Council. Our philosophy is to treat each patient who uses our system in the most appropriate setting of care, providing each patient with the most appropriate level of care to address their needs and at the best price possible (cf. #3 and #5).

It is this philosophy that motivated Sharp to embrace the PSRC model of care and apply to become one of 13 designated sites in the California demonstration project. The demonstration will conclude in September 1994 following deliberation by the legislature of a report to be prepared and issued by the Office of Statewide Health Planning and Development regarding the outcomes of the demonstration and the Office's recommendation for how to incorporate PSRC into the state's facility licensing framework (cf. #1 for this paragraph).

The Sharp PSRC is a 20-bed, hospital-affiliated, freestanding facility located in a medical office building across the street from Sharp Memorial Hospital and across the parking lot from the Sharp ASC. The policies and procedures which govern operations as well as the protocols which define our care at the PSRC are derived from hospital protocols. The PSRC has an organized medical staff with over 200 credentialled members. Our credentialling process is identical to our hospitals'. Our quality assurance program is outcome-oriented and is modeled after our hospitals' QA program. It is also based on JCAHO standards for similar inpatient services. We support an active QA committee, which is comprised of our medical director, our director of nursing, a staff nurse and a representative of each surgical specialty whose procedures we recover. Our nursing staff is comprised of licensed practitioners. Each of our RNs is certified for Advanced Cardiac Life Support, with a surgical specialty background (cf. #4 for this paragraph), while most of our LVNs are also ACLS-certified.

The ways in which we differ from our sister hospitals is that we primarily serve a healthy patient with a healthy history who is in need of acute nursing care following routine or elective surgery. Our patients therefore can schedule their recovery with us in advance, which permits us to be able to plan for the availability of both human and non-human resources to support our operations. Our interior environment is less institutional than that of a hospital medical/surgical unit. It was specifically designed to create a warm, more comforting ambiance with furnishings such as quilts and pine armoires that one would expect to find in a home (cf. #5). Our facility is quieter and less harried than the usual hospital unit with comfortable public spaces for use of both our patients and their families (cf. #5). We believe all of these factors contribute to a sense of wellness rather than illness and, in so doing, to a speedier recovery (cf. #4). In fact, preliminary data shows that our lengths of stay are lower than that for similar procedures recovered in the hospital, though this outcome was not originally expected by the demonstration project's administrators (cf. #3).

In response to the comments which are made that PSRCs provide a substandard quality of care to their patients, I would like to describe for you our quality assurance efforts. First, I want to reiterate that the medical staff credentialling process which we employ, which is identical to that which our sister hospitals use. Our quality assurance responsibilities are prescribed in regulation and mirror those required of hospitals in our state. We employ very stringent admission criteria, which we revise regularly to incorporate that which we are learning about

how we can best serve our patients' needs. These criteria are included in the written materials we have submitted to the Task Force. Each patient is screened at several points prior to their admission to the PSRC. First, when the procedure is scheduled, we speak with the patient and review the procedures with them. We send them an orientation package and recommend to them that they visit the PSRC prior to the day of surgery. On the day of surgery, the surgery program checks in with us to let us know that the patient is actually having the surgery as scheduled. Then, when the patient is moved into the Post Anesthesia Care Unit ("PACU"), the PACU nurse contacts us to inform us about the patient's post-surgical condition. We require all patients to remain in the PACU for a minimum of 2 hours, at which time, the next check is made as to the patient's condition. If their post-operative vital signs are within 20% of their pre-operative values, we schedule a pick-up. Each of these checks is documented in the medical record. The patient is picked up in a specially-equipped transport vehicle, which is staffed by an Emergency Medical Technician and a nurse (cf. #4 for this paragraph).

The results of our deliberate efforts is that less than 1/2 of 1 percent of all patients recovered at the Sharp PSRC have had to be transferred to a hospital (cf. #4). In most cases, the contributing factor was the need for additional surgical repair. Over ninety-nine percent of all patients are discharged to home. In addition, each patient is contacted following discharge to monitor their recuperative progress.

Why then should Illinois test the postsurgical recovery center concept? First, our physicians tell us that they believe that their healthy patients should have the ability to select the PRC option when they are undergoing an elective or routine surgical procedure, since the need for hospitalization is no longer automatically dictated for every patient, in much the same way as same-day surgery is the option of choice for many surgical procedures which used to necessitate a hospital stay. They view the PRC as permitting them to match more specifically each of their patient's particular needs with an appropriate post-surgical program, be it a hospital, a PRC or home care (cf. #4 and #5).

Our patients, who have given us a 98+% satisfaction rate, tell us that they appreciated being offered the PRC option by their physician and would select it again and tell others about this new option (cf. #5). In particular, they like being in such a serene atmosphere and appreciate the ease with which they can get up and walk around the facility and help themselves to satisfying foods.

The payors with whom we have established a relationship are beginning to see the pricing benefits we can offer to them and welcome the continuation of the operation of PRCs in our state. We on the other hand would welcome the recognition and participation of HCFA in the demonstration, so that we could demonstrate our ability to serve a cross-section of patients regardless of their source of reimbursement (cf. #3 for this paragraph).

As an active member of various national, regional and statewide hospital and professional associations, Sharp and its staff attempt to stay familiar with the changing needs and concerns of hospitals around the country. We are aware, therefore, that hospital associations tend to view PRCs negatively when they first hear about them. In California, for example, our hospital association initially opposed the PRC demonstration bill. Sharp recognized the issues which CAHHS was citing as problematic and, when Sharp became designated as a PRC demonstration site, we offered our support to CAHHS to work through these issues, so that CAHHS could see how and why a hospital could benefit and improve its services to the community by offering the PRC setting of care. Today, CAHHS no longer actively opposes PRCs and is collaborating with Sharp to test the concept through the demonstration.

PRCs are not for every community or for every hospital in California or in Illinois. But, they represent a logical step in the health care system's evolution, as surgical techniques and

anesthetic agents improve to the extent that surgery no longer has to subject the patient to the degree of trauma that it did even 10 years ago (cf. #4). Further, patients are seeing themselves more and more as "consumers" of health care and want choice to be a feature of our health care delivery system. It may be difficult to convince them to give up that choice solely for the reason that our planning to date has not resolved the conflict between the imperative to innovate and filling an available hospital bed. Illinois has the chance to put this innovation in inpatient acute care to the test for its citizens. We encourage you to do so, so that you can learn, as we have, of the excellent outcomes that postsurgical recovery centers can produce for both the quality and price of surgical care.

Response to question by Dr. Goyal regarding the proportions of bad debt and uncompensated care which the Sharp PSRC has experienced to date: Ms. Wayne will be forwarding a written response to this question to the Task Force upon her return to San Diego.

TESTIMONY OF CAROLYN A. CAINE

My name is Carolyn Caine and I am the President of the Surgical Recovery Center of Phoenix, Arizona. Recovery care is not a new idea. Though it is about to be tested here in Illinois, we opened SRC in 1979 and have been serving patients continually since then. SRC provides not only surgical recovery services, but also care for post-hospital and medical patients who require observation and nursing care. In Arizona, our facility's program is not limited as to the types of patients or procedures it can accommodate, nor the length of stay for each patient. Only our admissions criteria define the patients we serve and we subject each patient to these criteria prior to admitting them to our facility (cf. #4 and #5). All SRC patients must be admitted and discharged by their attending physician.

Though we are currently licensed by the State of Arizona, we are working with the state to establish a specific license for Recovery Care Centers. It is our hope that this license will be in place by the end of 1992.

We operate a 20-bed facility which is built to skilled nursing facility standards. We have been granted waivers by the state so that we can offer certain services via contract with other local providers rather than having to provide them ourselves. These services include pharmacy, physical therapy, clinical laboratory and radiology. SRC is managed by a Medical Director, an Administrator and a Director of Nursing. A Registered Nurse is on duty 24 hours a day and is supported by a staff of Licensed Practical Nurses and Nurses Aides. We are accredited by the Accreditation Association for Ambulatory Health Care under the "Overnight Stay" service category. Accreditation through the AAAHC has been available to recovery centers since 1988. We are now working with the Joint Commission on establishing JCAHO's recovery care accreditation standards (cf. #1 and #4).

To date, we have provided over 30,000 patient days of recovery care. We have been able to effectively handle each of our patients' needs in our 13 year history, including responding to the usual array of medical problems with which we have been presented (cf. #4). I believe that this is due in large part to a combination of our admission criteria, the quality of physicians with whom we work and our able staff, many of whom have been with us since we opened (cf. #4). Patients admitted to SRC are those who would have been admitted to an acute, inpatient facility in the past (cf. #5). The savings we have been able to achieve on behalf of the payors of the care we provide is approximately 30% across the board (cf. #3). SRC is a provider to most major third-party payors in our community, including Aetna, Metropolitan Life, CIGNA, Blue Cross/Blue Shield and many self-insured groups (cf. #3).

We ask each of our patients to tell us about their stay at SRC and how we can improve it for the future. Ninety-nine percent of our patients rate SRC as excellent in the areas of care, quality and services provided (cf. #4).

In addition, the physicians who use SRC are our best marketers. Once they have seen how well we care for their patients and how we accommodate their practice standards and needs, they are eager to refer other appropriate patients and, as well, to suggest to their colleagues that they consider SRC as an option for inpatient care of their patients (cf. #4 and #5).

The other hat I wear is as the founder of the National Recovery Care Association. The primary goal of this 3 year old trade association is to work with the Health Care Financing Administration to obtain recognition of recovery care as a reimbursable provider of inpatient care (cf. #3). Toward this end, NRCA has commissioned Lewin/ICF, a Washington, D.C. based consulting firm, to conduct a study of data from four operational recovery care centers to demonstrate the savings which can accrue to HCFA were it to recognize recovery care.

In conclusion, I would urge you to establish a recovery care demonstration, as I believe that Illinois' patients, physicians and payors would each benefit from this effective setting of care.

APPENDIX H.

SUMMARY OF PRESENTATIONS RELATED TO SELECTION CRITERIA AND MODEL DEFINITIONS: BIRTH CENTERS AND RECOVERY CARE CENTERS

ALTERNATIVE HEALTH CARE DELIVERY ACT

- BIRTH CENTER MODEL -

#	SELECTION CRITERIA	SUMARY OF PRESENTATIONS	DEFINITION FOR DISCUSSION
1.	feasibility of operating model in Illinois, based on a review of the experience in other states, including the impact on health professionals of other health care programs or facilities	Twenty-seven states currently license birth centers. While there is a recognized need for recruitment in shortage areas, data on the impact of birth centers on health professionals of other health care programs or facilities have not been collected.	Birth Center. A birth center is a designated demonstration program site which is away from the mother's usual place of residence in which births are planned to occur following a normal, uncomplicated, low-risk pregnancy. A birth center is either freestanding or a distinct part of an ambulatory surgical treatment center or hospital. A birth center shall maintain the ability to transport a patient with complications within 15 minutes under normal travel conditions to the contracting hospital. The maximum length of stay for patients in a birth center is not to exceed 24 hours unless the treating physician requests additional days from the birth center's medical director due to medical or clinical documentation that an additional care period is required for the recovery of patients. Reports on variances from the 24-hour limit shall be sent to the Illinois Department of Public Health for its evaluation. The reports shall, before submission to the Department, have removed from them any and all patient and physician identifiers. The birth center shall participate in the Illinois Perinatal System. In order to handle cases of complications, emergencies or exigent circumstances, every center as defined in this subsection shall maintain a contractual relationship, including a transfer agreement, with a hospital at which the physician on staff at the birth center has admitting privileges.
2.	potential to meet an unmet need	Birth centers have been established in areas lacking obatetrical care. For example, birth centers were established in California, Florida, Texas and New York in response to shortages in obatetrical care, in some cases due to physicians limiting or excluding from their practice patients whose care is covered by Medicaid.	
3.	potential to reduce health care costs to consumers, third party payors and aggregate costs to the public	Available data demonstrate cost savings to consumers and third-party payors, although no data on the impact on aggregate costs to the health care delivery system have been developed.	
4.	potential to maintain or improve standards of health care delivery in some measurable fashion	Birth centers comply with state licensure standards and follow the standards of the American College of Obstetrics and Gynecology, the American Academy of Pediatricians and the National Association of Childbearing Centers. A national study of birth centers reported positive outcomes, but was criticized for lack of a control group.	
5.	potential to provide increased choices or access for patients	Birth centers offer a choice that provides family-centered care and the absence of unneeded technology. Medicaid reimburses birth centers in about half of the states studied, so impacts on access are positive.	

ALTERNATIVE HEALTH CARE DELIVERY ACT

- RECOVERY CARE CENTER MODEL -

#	SELECTION CRITERIA	SUMMARY OF PRESENTATIONS
1.	feasibility of operating model in Illinois, based on a review of the experience in other states, including the impact on health professionals of other health care programs or facilities	Thirteen states have authorized postsurgical recovery centers, either permanently or on a demonstration basia, or are in the process of doing so. While there is a recognized need for recruitment in shortage areas, data on the impact of recovery care centera on health professionals of other health care programs or facilities have not been collected.
2.	potential to meet an unmet need	The potential of recovery centers to meet unmet needs in underserved areas is undocumented. The California legialation authorized only a *freestanding* rural demonstration site, which served as a barrier to testing the model in a rural community. Projected patient volume at the initial proposed site was not sufficient to support construction of a freestanding facility and provision of the basic set of services. An alternative that may addresa this issue in rural areas is to create a recovery center as a distinct part of another licensed health care facility.
3.	potential to reduce health care costs to consumers, third party payors and aggregate costs to the public	Preliminary data indicate cost savings to consumers and third-party payors, although no data are available on the impact on aggregate costs to the health care delivery system.
4.	potential to maintain or improve standards of health care delivery in some measurable fashion	Recovery centers generally comply with quality of care standards modeled on surgical recovery standards of acute care hospitals. Centers also voluntarily comply with accreditation standards for "overnight stay" developed by the Accreditation Association for Ambulatory Health Care. Work has begun on establishing Joint Commission on Accreditation of Healthcare Organizations' recovery care accreditation standards. Individual facilities report positive outcomes, with low transfer rates to hospitals. No study of quality of care in recovery care centers haa been conducted on a national basis; however, the California demonstration project will produce an evaluation report in early 1994, including an assessment of patient safety and the manner in which care is provided in postsurgical recovery care demonstration sitea in that state.
5.	potential to provide increased choices or access for patients	Studies indicate that recovery care centers offer increased choice to relatively healthy patients undergoing elective or routine surgical procedures. Because current HCFA guidelines do not allow Medicaid or Medicare reimbursement for recovery care, access for these populations is limited. Recovery care centers' ability to provide increased geographical access is undocumented.

DEFINITION FOR DISCUSSION

Postsurgical Recovery Care Center. A postsurgical recovery care center is a designated demonstration program site which provides postsurgical recovery care for generally healthy patients undergoing surgical procedures that require overnight nursing care, pain control, or observation that would otherwise be provided in an inpatient setting. A postsurgical recovery care center is either freestanding or a distinct part of an ambulatory surgical treatment center or hospital or skilled nursing facility. The maximum length of stay for patients in a postsurgical recovery care center is not to exceed 72 hours, unless the treating physician requests additional days from the recovery center's medical director due to medical or clinical documentation that an additional care period is required for the recovery of patients. Reports on variances from the 72-hour limit shall be sent to the Illinois Department of Public Health for its evaluation. The reports shall, before submission to the Department, have removed from them any and all patient and physician identifiers. In order to handle cases of complications, emergencies or exigent circumstances, every center as defined in this subsection shall maintain a contractual relationship, including a transfer agreement, with a general acute care hospital.

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